Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

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Table of Contents

- [Front Matter]
- Chapter 1--Introduction
- Chapter 2--Key Elements of Treatment Drug Courts
- Chapter 3--Program Planning
- Chapter 4--Designing the Program
- Chapter 5--Implementation
- Chapter 6--Program Evaluation
- Chapter 7--Program Costs and Financing
- Chapter 8--Legal and Ethical Issues
- Appendix A--Bibliography
- Appendix B--Federal Resource Panel
- Appendix C--Federal Resource Panel
- Exhibits

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[Front Matter]

[Title Page]

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The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized patient care and treatment decisions.

What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to assemble state-of-the-art protocols and guidelines for the treatment of substance abuse from acknowledged clinical, research, and administrative experts and distribute them among the Nation's substance abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with CSAT surveying a wide-ranging group of substance abuse experts, including clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice. From their suggestions of areas in the field that lack consensus or guidance, a topic is selected.

CSAT then appoints staff from pertinent Federal agencies and national organizations to a Federal resource panel that studies treatment and program management in the area selected. Recommendations from this Federal panel are transmitted to the members of a second group, made up of non-Federal experts who are intimately familiar with the topic. Members of this Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. This panel meets in Washington for 5 days to discuss the Federal panel's recommendations, review and analyze the literature, and outline protocols for best practices. The panel chair is charged with ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a large and diverse group of expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. The result is a TIP reflecting the actual state of the art of substance abuse treatment in public and private programs recognized for their provision of high quality and innovative substance abuse treatment.

The primary objective of this TIP, titled *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing*, is to help policymakers and practitioners plan,

implement, monitor, and evaluate programs that effectively integrate treatment in the pretrial processing of criminal cases. TIP 12 in this series, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, focuses on treatment options for offenders after they have been found guilty by a judge or jury.

A focus on treatment intervention during the pretrial process has important implications for the nature of the interrelationship between the justice system and treatment providers. Defendants who have been arrested but not yet convicted are legally presumed innocent; they cannot be compelled to participate in a treatment program.

The focus on pretrial intervention also has implications for decisions about the categories of individuals who will be targeted for intervention; for the nature and timing of screening and assessment activities; for the consequences that can be imposed for treatment "failure" or noncompliance with conditions; and for a host of other program design and implementation issues.

This TIP was developed to encourage agencies creating and participating in these programs to share information about their successes -- and failures -- so that substance abuse treatment will be effectively integrated into pretrial case processing.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve substance abuse treatment.

Other TIPs may be ordered by contacting The National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debate and discuss their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

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Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Chapter 1 -- Introduction

Substance abuse is a long-standing problem in American society, one closely linked to societal problems from dysfunctional families and child abuse and neglect to unemployment, economic underdevelopment, and crime. The numbers of Americans who abuse alcohol and other drugs are staggering. During any given month during the last 20 years, at least 14 million and sometimes as many as 25 million Americans used some type of illicit drug (Gerstein and Harwood, 1990). Recent conservative estimates indicate that about 17 million Americans suffer from some form of alcoholism or alcohol abuse National Institute on Alcohol Abuse and Alcoholism, 1993).

While drug-related cases have long been part of the caseloads of the Nation's courts and other criminal justice agencies, substance abuse problems recently have inundated the courts. In the late 1980s, as law enforcement agencies implemented or expanded strategies that emphasized the arrest and prosecution of users and street-level dealers, drug-related felony cases piled up in the courts. The increased volume of cases, coupled with the enactment of laws by the Federal Government and many States that require mandatory terms of imprisonment for drug-related offenses, produced a sense of crisis in many American courts. For example, according to the report of a 1989 conference attended by court system leaders from the Nation's nine most populous States, "the general sense was that most trial courts are being overwhelmed by drug cases." Conferees warned of "either an imminent or existing caseload crisis and possible breakdown of the system if solutions are not found soon" (Lipscher, 1989). The well-documented increase in jail and prison populations around the Nation is directly attributable to the upsurge in the prosecution of drug charges and related crimes fueled by drug abuse.

The search for solutions has led State and local jurisdictions to try a variety of approaches in handling drug-related cases. One of the most innovative approaches is integrating substance abuse treatment with the pretrial processing of criminal cases. These programs are known as "drug courts" or "treatment drug courts." No two of these programs are exactly alike, but common threads run through them all.

While drug-related cases have long been part of the caseloads of the Nation's courts and other criminal justice agencies, recent developments have made substance abuse problems a pressing concern of the courts.

What Are Treatment Drug Courts?

While they vary widely in scope, organization, and points of intervention, all the treatment drug courts developed in recent years share an underlying premise that drug possession and use is not simply a law enforcement/criminal justice problem but a public health problem with deep roots in society. All of these drug court programs see the court, and specifically the judge, as filling a role that goes beyond that of adjudication.

In drug court programs, criminal justice agencies collaborate closely with the substance abuse treatment community and other societal institutions to design and operate the program. As Goldkamp (1993) describes in his report of the first National Drug Court Conference, "These courts rely on strong collaboration among judges, prosecutors, defense lawyers and related supporting agencies (such as case management, corrections, pretrial services, probation, etc.), on the one hand, and a partnership with treatment agencies (or providers) and other community organizations and representatives on the other." These programs are based on an understanding that substance abuse is a chronic, progressive, relapsing disorder *that can be successfully treated*. The success of these programs is built on the fact that the post-arrest period can provide a particularly good opportunity for interventions that will break the drug-crime cycle.

Most programs incorporate the following key principles recommended in legislation developed by the President's Commission on Model State Drug Laws:

- Early identification of defendants in need of treatment and referral to treatment as soon as possible after arrest
- Early and professional diagnosis of defendant's treatment needs
- Matching those needs to specific treatment programs
- Making treatment a court-monitored requirement and providing for judicial review and supervision of the defendant's progress in treatment
- Holding defendants accountable through a series of graduated sanctions and rewards
- Providing aftercare and support services following treatment completion.

Drug court programs involve the close collaboration of the criminal justice system with the substance abuse treatment community and with other societal institutions.

Potential Benefits of Systems Integration

The recognition that treatment works -- not in every case, but often enough to make treatment-oriented drug courts a better alternative than conventional case processing for some defendants -- is a key operating premise of drug courts. However, for treatment to work, a number of individuals and institutions must cooperate and collaborate.

When collaboration among systems works well, the benefits to individuals and to society can be enormous. For drug-involved defendants, the possible benefits of effective collaboration include

- Improved physical and mental health, including recovery from addiction
- The opportunity for education and employment
- Improved social functioning
- The opportunity to become a productive member of society
- A favorable disposition of a court case (such as dismissal or significant reduction of the charges).

The court system benefits because of the effective disposition of many drug cases and because caseload pressures are eased, allowing the system more time for non-drug cases.

For society, the possible benefits of effective collaboration include

- Reduction in criminal behavior
- An improved workforce
- Reduction in spread of substance abuse-related diseases
- Reduced medical costs
- Reduction in incarceration costs.

The public health benefits of effectively integrating substance abuse treatment and criminal case processing are especially important. A high proportion of the defendants in criminal cases have substance abuse problems. Some defendants already have one or more of the infectious diseases often associated with substance abuse, such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis (TB), and hepatitis.

Defendants with compromised immune systems are at risk of acquiring TB, especially if they are confined in crowded jails after arrest. The drug court process can help identify defendants who have contagious diseases and thus prevent the spread of disease. The screening process can also uncover defendants' underlying mental health problems, which may be contributing to interpersonal and family violence.

Programs integrating substance abuse treatment with justice system case processing offer many opportunities for court system leaders, trial court judges, and other justice system practitioners who handle substance abuse-related cases. They can break new ground, help shape policies and practices that will improve the lives of people who are involved in criminal cases, and help forge new relationships among courts, substance abuse treatment providers, public health agencies, and other societal institutions. The challenge is to do so in a fashion that is consistent with fundamental principles of fairness and due process of law.

The benefits to society include reduction in criminal behavior, an improved work force, improved social functioning of defendants, reduction in the spread of substance abuse-related disease, and reduced medical costs.

Drug courts first appeared in 1989 and have multiplied since 1992. In 1996, over 125 drug courts were operating in 45 States and more than 100 jurisdictions, and 24 were being developed. At least 25 had operated for two years or more, supervising an estimated 20,000 participants.

The collaborative planning, program design, and implementation that have taken place already in the fledgling drug courts prove that integration of substance abuse treatment and justice system case processing is feasible. A study of the Miami Drug Court (the first in the nation) conducted for the National Institute of Justice found both success in treatment and reduced re-arrests among defendants processed in treatment-oriented drug courts.

The researchers focused on defendants over an 18-month period and compared them to similar defendants not in the program. They found that among Drug Court defendants, there were

- Fewer cases dropped
- Lower incarceration rates
- Less frequent arrests
- Longer times before subsequent re-arrests
- Higher failure-to-appear rates, caused mainly by the more frequent appearances required of Drug Court defendants(Goldkamp and Weiland, 1993).

Scope and Objectives of This TIP

This Treatment Improvement Protocol (TIP) focuses on the integration of substance abuse treatment with criminal justice system operations during the *pretrial* stages of criminal cases. Although these are the boundaries of the discussion in this TIP, we recognize that some treatment drug courts work with post-adjudicated individuals as opposed to individuals in the pretrial phase of the criminal justice system. TIP 12 in this series, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT, 1994d), focuses on post-adjudication treatment options for *offenders*, that is, those who have been found guilty.

The consensus panel for this TIP recognizes that not all treatment programs or all substance-abusing individuals can be neatly categorized as either "pretrial" or "post-adjudication." The treatment drug court concept started as an identifiable package of clear elements that has been adapted to fit local circumstances; different locations have attempted to address similar issues in different ways. Many substance abuse treatment programs that accept court referrals handle both pretrial defendants and sentenced offenders. It is also possible for an individual to be in more than one category at one time. For example, an offender could be participating in a substance abuse treatment program as a condition of probation following conviction on one offense and become a pretrial defendant by being arrested on a new charge.

There are, however, some unique aspects to the linkage between substance abuse treatment and the *pretrial* processing of criminal cases. Defendants who have been arrested but not yet convicted are legally presumed innocent and cannot be compelled to participate in a treatment program. A judge can, however, exercise significant authority over pretrial defendants, including ordering drug testing and treatment as conditions of release from pretrial detention. The authority

of the judge to establish conditions of pretrial release and to defer prosecution or sentencing is critically important for the development of programs linking substance abuse treatment and pretrial case processing.

The adoption of pretrial intervention also has implications for decisions on who is targeted for intervention; for the nature and timing of screening and assessment activities; for sanctions imposed for noncompliance; and for many other program design and implementation issues. For example, a program that dismisses the charges of those who complete community-based drug treatment could apply to only those defendants whose current charges do not involve violence or other offenses imprisonable upon conviction. And, because treatment is to be initiated and monitored during the pretrial process, a great deal of information about the defendant must be acquired and processed quickly to make an informed decision on program admission. This puts a premium on accurate and reliable information and on the ability of criminal justice agencies, courts, substance abuse treatment providers, and public health services to exchange information quickly.

A pretrial defendant cannot be compelled to participate in a treatment program: The decision to participate is the defendant's.

The Diversity of Drug Court Models

There is no single model for the integration of treatment and pretrial case processing; jurisdictions have developed a wide range of drug court models. Among them are

- Use of "supervised release" or "conditional release" mechanisms, in which the defendant is released from pretrial custody under conditions that include regular or random urine screening and participation in a substance abuse treatment program
- Acceptance into a treatment program shortly after arrest, with an understanding that (a) further prosecution will be held in abeyance; (b) if the defendant successfully completes the program, the charges will be dismissed; and (c) if the defendant does not complete the program, prosecution will go forward on the original charge.
- Acceptance into a "deferred judgment" program or "post-plea diversion" program shortly after arrest, under which the defendant pleads guilty to a criminal charge (for example, unlawful possession of drugs) with the understanding that (a) sentence will be deferred; (b) if the defendant successfully completes the program, the plea of guilty will be vacated and the charges dropped; and (c) if the defendant fails to complete the program, sentence will be imposed on the original charge.
- Use of jail-based treatment programs for pretrial defendants who are not released from custody and for defendants participating in a conditional release, diversion, or deferred adjudication treatment program who relapse into using alcohol or illegal drugs.

Some examples from drug courts are provided inExhibit 1-1.

The Purpose of This TIP

The primary objective of this TIP is to help policymakers and practitioners plan, implement, monitor, and evaluate programs that integrate substance abuse treatment with the pretrial processing of criminal cases.

The TIP does not advocate one type of program model. It does emphasize the *integration* of court processing and treatment services common in most recently developed programs. In those collaborative drug courts, a defendant's case is generally diverted from the usual course of prosecution, but the court monitors the defendant/client's treatment progress along with the clinician. With input from the treatment provider, the judge may impose sanctions (consequences) when it is apparent that the defendant has failed to comply with program requirements. By the same token, the judge may "reward" progress by making conditions of release less stringent or by publicly acknowledging an individual's progress in open court. The result is a much stronger and more active partnership between the justice system and the treatment community than existed in earlier diversion programs.

This TIP has been developed by a panel of practitioners from a number of different disciplines and different jurisdictions, almost all of whom have had first-hand experience with such integrated programs. Panel members believe that this kind of systems integration has great potential for improving the quality of justice and the effectiveness of substance abuse treatment. The document is intended to assist other practitioners in conceptualizing, planning, and implementing programs that will work for their jurisdictions.

Organization of This TIP

The remaining seven chapters address the key issues involved in planning, implementing, and evaluating programs that integrate substance abuse treatment and pretrial case processing.

Chapter 2, "Key Elements of Treatment Drug Courts," describes critical components of effective multisystems integration, taking account of the goals and perspectives of the justice system, the treatment community, and the public health system.

Chapter 3, "Program Planning," describes the initial formation of a planning committee and its activities, especially in regard to early policy decisions such as selecting the target population.

Chapter 4, "Designing the Program," focuses on nine key sets of operational issues, such as screening and assessment, that must be addressed in designing the day-to-day operations of the program. The chapter includes a broad overview of the range of substance abuse treatment modalities and the components that constitute effective treatment. Another section describes types of diversion programs already in existence and discusses the roles of the judge, prosecutor, defense counsel, and other practitioners involved in programs that integrate substance abuse treatment and pretrial case processing.

Chapter 5, "Implementation," focuses on staff training and education, public relations, and other issues that may arise in the pilot period of the program.

Chapter 6, "Program Evaluation," addresses evaluation strategies and techniques.

Chapter 7, "Program Costs and Financing," focuses on identifying program costs and developing funding sources. Approaches to estimating costs and benefits are described.

Finally, Chapter 8, "Legal and Ethical Issues," discusses such issues as they arise in providing substance abuse treatment to defendants during the pretrial stages of a criminal case.

Endnote

Information about the drug court experiences is drawn from a variety of documents, many of which are in the collection of The Bureau of Justice Assistance Drug Court Resource Center at American University School of Public Affairs. See especially Cooper, Caroline, *An Overview of Operational Characteristics and Implementation Issues* and Cooper, Caroline, and Joseph Trotter, *Drug Case Management and Treatment Intervention in the State and Local Courts, Volumes I and II*, published by American University in 1995. See also John S. Goldkamp, *Justice and Treatment Innovation: The Drug Court Movement "A working paper of the First National Drug Court Conference December 1993"*, a report on the First National Drug Court Conference published by the National Institute of Justice and the State Justice Institute.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
Treatment Improvement Protocol (TIP) Series 23

Chapter 2 -- Key Elements of Treatment Drug Courts

Successful collaboration among the substance abuse treatment system, the public health system, and the criminal justice system requires that practitioners in each system understand the values and perspectives of the other systems. Effective systems integration depends on practitioners' ability to

- Develop and clearly state shared goals
- Jointly obtain, exchange, and use information
- Engage in ongoing communications about individual cases and systemic issues
- Develop operational procedures that meet the needs of the individuals in treatment and take into account the available resources of the participating institutions
- Perhaps most importantly, exercise strong leadership within each system.

This chapter describes the values and perspectives of each of the collaborating systems and discusses each of the areas listed above. This discussion will help practitioners in all systems integrate substance abuse treatment in the pretrial processing of criminal cases.

Understanding Each System's Basic Values and Perspectives

Significant differences in the philosophies, activities, and structure of the three systems pose a challenge to collaboration, as do the differences in goals, values, and approaches to specific problems. However, there are some important values that are broadly shared by practitioners who work within the substance abuse treatment, public health, and criminal justice systems.

Justice System

The justice system is based in law, state and local procedures, and the local legal culture. Courts are at the center of the adjudication process, which in criminal cases is typically adversarial. Charges are brought by a prosecutor on the basis of evidence gathered by the police or another law enforcement agency. The defendant is usually represented by a defense lawyer, required if the charges are serious enough that they could result in incarceration upon conviction. A judge presides over court proceedings in the case. The judge

- Advises defendants of their rights

- Sets conditions of pretrial release
- Conducts hearings and trials and determines guilt or innocence
- Sentences defendants who plead guilty or are found guilty after trial.

The judges, prosecutors, and defense lawyers who work in the criminal courts naturally approach a case involving a substance-abusing individual as a legal matter. The nature of the defendant's substance abuse problem is, if it is discussed at all, a secondary issue. The primary focus is on the defendant's guilt or innocence with regard to the criminal charges that led to arrest and prosecution. The differences between the two types of courts are summarized in Exhibit 2-l.

However, while the criminal laws and related public safety concerns are important for justice system practitioners, they are by no means the only values that influence the operation of the system. Other broadly shared goals include

- **Due process**. Justice system practitioners place a high value on both the appearance and the reality of even-handedness in the administration of justice. This means that defendants charged with the same offense who have similar criminal records and other relevant characteristics in common will be treated in a consistent fashion.
- **Protection of individual rights**. Defense lawyers have a special role as guardians of a defendant's legal rights. All justice system practitioners are concerned with upholding these rights -- including the right to representation of counsel and the right to make informed choices about available alternative courses of action during the pretrial process.
- **Expeditious resolution of cases**. The swift resolution of cases is important for victims, defendants, and the public. Systemic delay can undermine the court's credibility, lessen the quality of justice, and impair the court's ability to take on new programmatic initiatives.
- **Appropriate disposition**. While practitioners with different roles and responsibilities may disagree about the appropriate disposition of a particular case, they tend to view the relative severity of different offenses and appropriate dispositions for particular types of criminal conduct roughly the same way. Of particular relevance for this Treatment Improvement Protocol (TIP), there appears to be an emerging consensus among justice system practitioners that prison is a scarce resource, best used for individuals who are genuine threats to public safety. There is a growing awareness that incarcerating individuals for drug use or possession may not be an effective use of prison space and that substance abuse treatment has a far greater likelihood than incarceration of reducing future criminal behavior by addicted individuals.

Justice system practitioners increasingly view prison as a scarce resource that may not be the best place for those charged with drug use or possession.

Substance Abuse Treatment System

The treatment system's primary purpose is to end or alleviate a client's substance abuse. Practitioners in the system generally adopt a health promotion/disease prevention model in which

the treatment professional works with the client to overcome what is seen as a biopsychosocial disease or disorder. The term biopsychosocial is used to indicate that biological, psychological, and social factors are deeply woven into the development of addiction. These factors must be addressed in order for treatment to succeed. Substance abuse treatment practitioners recognize that some types of substance abuse involve possession and use of illegal drugs, but their primary concern is not with the illegality of the activity; rather it is with the recovery from addiction.

Substance abuse generally becomes more severe over time; if left untreated, the disease can be fatal. Substance use disorders cannot be "cured," but many individuals can make the behavioral changes necessary to recover.

The treatment community recognizes that relapse is a common feature of addiction. Indeed, relapse -- a return to addictive behavior -- may sometimes be a step (or misstep) on the path to recovery, rather than a failure. It is not uncommon for an individual to alternate between treatment and relapse before completely recovering.

Treatment practitioners note that the progression of the severity of substance abuse can be depicted on a continuum that ranges from experimentation at one end to recovery or death on the other. The goals of treatment, which apply to every stage of the continuum, are

- To reduce the incidence and prevalence of the chronic, progressive abuse of alcohol and other drugs
- To provide a system of services to assist people, their families, and communities in recovering from addiction
- To decrease the number of people at risk for addiction.

Matching people to the appropriate level of care and providing a range of support services (for example, medical care, child care, housing, job training, and aftercare) are key elements of the treatment process. Support services allow individuals to make effective use of substance abuse treatment. Careful assessment both of the person's severity of addiction and of the range of problems related to substance use, such as medical illness, family and social problems, legal problems, and lack of adequate housing and nutrition, is critical to client-treatment matching. Successful treatment generally includes some form of supportive, drug-focused individual and/or group counseling to identify relapse triggers and provide long-term support. Self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous, while not considered treatment, help many successfully recover.

Services provided to people at different stages of the disease can be divided into three categories: (1) pretreatment services (prevention, including education about the dangers of substance abuse), (2) outpatient treatment, and (3) inpatient treatment (including residential treatment). Most drug courts target services for persons in the latter two stages, although prevention services may be provided for those who are minimally involved in drug use. For a more detailed description of treatment approaches and modalities, see Chapter 4.

Public health's "big picture" approach contrasts sharply with the justice system's focus on *individual* clients or defendants.

Public Health System Values and Perspectives

Public health practitioners are focused on the health of entire communities. Indeed, public health can be defined as organized community activities that promote the improvement of physical, occupational, behavioral, and social health. The public health system is grounded in an epidemiological approach that studies the determinants of disease and health risks, their distribution, and the incidence of disease across and within population subgroups. It is a "big picture" approach quite different from the focus on *individual* clients or defendants that is characteristic of many substance abuse treatment and justice system practitioners.

Public health goals include health promotion and disease prevention, which depend on the interrelationship of health and social service agencies. The early stages of criminal case processing present a valuable point of public health intervention, because many people arrested have substance abuse problems accompanied by infectious disease. Well-designed screening to identify criminal defendants with substance abuse problems can also help identify defendants who have HIV/AIDS, other sexually transmitted diseases (STDs), TB, and hepatitis B. Referral to treatment will not only help such defendants, it will also help prevent further spread of these diseases.

The early stages of criminal case processing present a valuable point of intervention, because many who are arrested have substance abuse problems accompanied by infectious diseases.

Addressing Value Conflicts

Values inherent in one of the three systems sometimes conflict with those of another. For example, two of the best-known harm reduction strategies advocated by some public health professionals are needle exchanges for addicts and condom distribution, both designed to prevent the spread of HIV and other sexually transmitted diseases. Many people within justice agencies believe these public health programs condone illegal drug use.

Similarly, some substance abuse treatment programs have a "controlled use" orientation. A provider in such a program may condone or even applaud a client moving to a lower level of drug use or reducing frequency of use. However, when the drug being used is an illicit one, a controlled use orientation may be unacceptable to criminal justice agencies.

Problems can arise when courts, criminal justice agencies, and other public institutions form partnerships with treatment agencies and adopt harm reduction strategies that are not acceptable to some groups in the community. Such situations can be difficult for justice system leaders,

especially if the goals and operational procedures of all the partners are not clearly understood before agreements are signed.

Developing Shared Goals

Given the range of values and philosophical world-views, it is critical that leaders in each system understand each other's values, perspectives, and priorities. Only then can policymakers and practitioners develop a set of shared goals. The process of developing shared goals compels policymakers to think through the reasons for instituting the program, assess what can be accomplished with the available resources, and consider what structural and procedural changes may be necessary for the success of the program. The potential benefits of integrating substance treatment with pretrial case processing can be a starting point for developing shared program goals.

Following are the five goals of collaborations among the treatment, justice, and public health systems:

- Reduced criminal behavior: fewer repeat offenders
- Better use of limited jail space: fewer addicted prisoners and more jail space for those who pose public safety risks
- Improved delivery of treatment services: more effective treatment for a significant population of substance abusers
- Effective disease prevention and treatment: better health status for substance abusers as well as prevention and treatment of infectious diseases
- Improved productivity: greater employment and reduced dependence on social services and health systems.

The Key Role of Information

In setting goals and developing program structure and operational procedures, planners need frequently updated information from all three systems -- the justice system, the treatment system, and the public health system.

Timely and accurate information is especially important for programs that provide treatment intervention in the *pretrial*stages of criminal cases. The immediate post-arrest period is a time when critical justice system decisions are made about a defendant, including decisions about specific charges to be filed, conditions of custody or release, and appointment of defense counsel. To enroll a person who has been arrested in a substance abuse treatment program, everyone involved -- especially the court, the prosecutor, the defendant, and defense counsel, and the treatment provider -- will need accurate information on some key topics:

- The nature and circumstances of the current charge
- The defendant's criminal record
- The status of any pending cases
- The nature and severity of the defendant's substance abuse problem(s)
- The defendant's treatment history

- The defendant's mental and physical condition, including the presence of any infectious diseases
- Based on the information gathered, the availability of a treatment "slot" appropriate for the defendant.

Obtaining such information can be a challenge under any circumstances, and it is a major challenge to do so in the 24- to 72-hour period advocated by proponents of rapid treatment intervention. However, as a number of jurisdictions have demonstrated, it is possible. According to a recent American University survey, the following treatment drug courts screen dependents within 72 hours and begin assessment and treatment intervention within 1 day: District of Columbia (Superior Court); Fort Lauderdale, Florida; Kalamazoo, Michigan; Las Vegas, Nevada; Seattle, Washington; and Kansas City. It is also possible to design information systems that give everyone involved quick access to information on defendants' performance in treatment and their compliance with other conditions of release set by the court. This rapid transfer of information allows both systems to manage cases and interested parties to follow the program's and individuals' progress.

Traditionally neither courts, criminal justice agencies, nor substance abuse treatment providers have shared information like this, so they must all move forward carefully. Information transfer must abide by confidentiality laws designed to protect privacy of individuals (see Chapter 8), and it may require investment in computer hardware and software. When the commitment to share information is made, as it has been in some jurisdictions, the benefits -- in terms of sound program management and informed decision-making -- are enormous.

Leadership

In studies of corporate and public sector innovation and excellence, effective leadership consistently emerges as a critical factor. It will undoubtedly be a key factor in the success of any program aimed at integrating substance abuse treatment with pretrial case processing.

In this context, it is important to emphasize the necessity of *collaborative* leadership. While individual judges and prosecutors led the way in establishing most of the successful the drug court programs, they were supported by a wide range of individuals in top and middle management positions in the courts, other justice system agencies, the treatment community, and other public and private institutions.

Leadership in this area is not limited to the top managers of the institutions involved. There is plenty of room for leadership at middle management levels, too -- in the courtroom, in treatment clinics, in public health agencies, and in the broad array of criminal justice, educational, and social services agencies that become involved in a comprehensive approach to treating the substance abuse problems of defendants in criminal cases.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
Treatment Improvement Protocol (TIP) Series 23

Chapter 3 -- Program Planning

Planning a program that integrates substance abuse treatment with pretrial case processing will vary somewhat across jurisdictions, reflecting the organizational structure of the particular justice system, substance abuse treatment system, and public health system. The program will also reflect the specific legal framework, traditions, personalities, and "local legal culture" of the jurisdiction. Yet every jurisdiction must **answer** six basic **questions** when planning a pretrial treatment program:

- Who will be in the planning group?
- How will the planning group work?
- What information is needed to develop policy and shape program goals and objectives?
- Who makes up the program's target population and when during the pretrial process should the intervention happen?
- What treatment and other resources will be used?
- What will be in the Memorandum of Understanding (MOU) that incorporates commitments from all the key stakeholders?

Who Should Be Involved?

For a pretrial substance abuse treatment program to work successfully, it must have the support-or at least the acceptance-of leaders in the courts, other criminal justice agencies (especially the prosecutor's office and the defense bar), the treatment community, and other institutions. At the county level the level of government at which most trial courts are organized and at which the pretrial stage of criminal case processing usually takes place -- the following **stakeholders** should be considered for inclusion on a policy or advisory group to plan a pretrial drug treatment program:

- Chief or presiding judges of the general and limited jurisdiction courts
- Prosecutor
- Public defender
- Representative of the private defense bar
- Court administrator
- Case management agency administrator
- Pretrial services agency director

- Chief probation officer/director of community corrections agency
- Sheriff/jail administrator
- Substance abuse treatment professionals
- Major health institutions/hospital director
- Public health agency director
- Social services agencies, including child protective services
- Local school districts, community colleges, and other educational institutions
- Medical services and community mental health providers
- County commission/senior staff (including budget director)
- Victims' rights groups
- Ex-offender/ex-addict groups
- Community anticrime and antidrug coalitions.

In addition to these community stakeholders, there are important State-level stakeholders as well. Individuals with substance abuse disorders frequently move across county lines, so State-level funding and legislative or rule-making support may be necessary. Further, trial courts function within an organizational framework in which State appellate courts (especially States' supreme courts) and the State court administrator's office shape policy and practice at the trial court level. Moreover, funding and coordination of substance treatment programs is centered at the State level in the office of the State Alcohol and Drug Abuse Director (known in the treatment community as the Single State Agency). Other key stakeholders at the State level are likely to include

Chief Justice

- State Court Administrator
- State legislative leaders
- Governor
- State health and social services department heads.

As a practical matter, it is very difficult for a group this large to do detailed planning. However, it is possible to elicit ideas and concerns from all, to take their views into account in shaping initial plans, and to keep them abreast of developments in the planning process. The detailed planning can be done by a smaller, representative group. The composition of such a "subgroup" is likely to vary from jurisdiction to jurisdiction but should certainly include justice system and substance abuse treatment community leaders.

Judges, especially chief and presiding judges, play critical roles in the planning process because the courts, more than any other entity, will link pretrial processing with substance abuse treatment. It is a judge who will make the diversion or "conditional release" decision to place a defendant in the program. Administrative personnel in the court will monitor the defendant's compliance with conditions set by the judge. Also, because they are known as "neutral parties," judges are in a unique position to bring the relevant stakeholders together in the planning committee.

Judges, especially court and presiding judges, have critical roles to play in the planning process because the courts, more than any other entity, will link pretrial processing with substance abuse treatment.

Prosecutors are important stakeholders as well. They shape overall law enforcement policies in their jurisdictions, establishing policies for filing formal criminal charges. For individual cases, prosecutors decide what specific charges to file and recommend conditions of custody or release, acceptable pleas, and components of a sentence. Sometimes they may also manage diversion programs through their own offices.

The defense bar (particularly the public defender's office, if the jurisdiction has one) should also be involved in planning a drug court program. Defense lawyers may well be skeptical about advising their clients to participate in a program that, in terms of its duration and conditions, may seem more onerous than the disposition that would generally occur. Involving defense lawyers will help ensure that the rights and interests of those for whom the program is designed are taken into account.

Substance abuse treatment professionals and the State Alcohol and Drug Abuse Directors (or their representatives) generally do not have specialized expertise in criminal justice issues, but their treatment expertise is essential for planning an effective drug court program. Often, they have experience working with health and social services agencies, and in some jurisdictions they may have a history of working with persons referred to them by the court. They also will be familiar with many of the funding opportunities and constraints relevant to program planning.

Planning Committee Structure

Dedication of Committee Members

Planning committee members must commit to meeting regularly throughout the planning period and during the subsequent implementation of the program to exchange information and to consider and decide on specific actions.

Staffing

The dedication of committee members will be strengthened if support staff services are available to the planning group. Dedicated staffing can help the committee coordinate its activities, develop agendas, keep a record of committee proceedings, gather the data necessary for planning the program and monitoring implementation, help develop specific proposals, and assist in ongoing analysis and administrative support.

How is the planning group staffed? There are at least three possible approaches:

- A staff-level workgroup can be formed, bringing together senior staff members from the court and other agencies represented on the planning committee.

- If the jurisdiction has a planning commission or criminal justice coordinating council, this body can assign staff to the planning committee. Typically, members of these bodies are also in the drug court planning committee and will already know about many of the involved agencies and issues.
- If the court, prosecutor's office, or a treatment provider consortium has initiated planning for the program, staff from that organization could support the stakeholder planning committee. Any of the three approaches, or a mix that includes elements of some of them, may be appropriate for a jurisdiction that is just beginning the planning process.

Key Tasks

The relationship between the planning committee and the staff will be unique in each jurisdiction, but there are some tasks that every planning group must address. They include

- **Describing the substance abuse problem** in the jurisdiction and the nature and prevalence of substance abuse among arrestees who are potential "targets" for treatment program intervention
- **Identifying target populations** and potential points of intervention
- **Determining the case management and treatment services that will be needed by target group members** and locating potential case management and treatment service providers
- **Addressing legal issues**, including program eligibility and acceptance criteria
- **Establishing the goals** for the program, including anticipated outcomes for defendants who participate in the program and the expected systemic improvements
- **Ensuring that adequate management information and tracking systems are in place** to enable program monitoring and evaluation
- **Developing written agreements (Memoranda of Understanding)** that reflect the interests of the stakeholders and their commitments to the program.

In carrying out these tasks, some members of the planning group will undoubtedly be more involved than others, because their day-to-day operations will be more directly affected by the plans that are developed. Trial court judges, treatment providers, and staff from the court, the prosecutor's office, the public defender's office, the pretrial services agency, the case management agency, and the jail, all of which will be involved in daily program operations, should be primary resources both in initial planning and in developing the detailed program design that will follow.

Trial court judges, treatment providers, and staff from the court, the prosecutor's office, the public defender's office, the pretrial services agency, the case management agency, and the jail all should be involved in planning and developing the program.

Information Needed for Program Planning

Both the policy-level leaders on the planning committee and the staff members involved in planning need several types of information about the jurisdiction to plan effectively. These include information about

- The potential target groups
- The type and number of defendants appropriate for diversion to treatment
- A case management agency
- Available treatment services
- The legal framework including any legal constraints that could affect program design and operation
- Costs
- Facilitation.

Information About Potential Target Group Members

Planners must be able to identify appropriate categories of defendants to be targeted for treatment intervention. This involves information about resources and political realities, as well as arrestees' characteristics and treatment needs. Specific questions to be addressed should include

- How much pretrial jail space is currently occupied by persons who have substance abuse problems, but who do not have a history of committing violent or predatory offenses? Is jail-based treatment available for pretrial defendants? If not, would it be feasible to start a jail-based program?
- To what extent do defendants released before trial have substance abuse problems? What is the frequency distribution by offense category?
- What characteristics of pretrial defendants would be considered positive indicators for participation in a pretrial substance abuse treatment program? What is the distribution by custody status and offense category? How many defendants fall into these categories in the course of a year?
- What prior criminal history or other defendant characteristics do key stakeholders view as preemptively excluding a defendant from program participation?

Of the defendants who have substance abuse problems and who might be considered for participation in a pretrial substance abuse treatment program

- What is the distribution of the substance abuse problems (including types of substances abused and levels of severity of abuse)?
- What is the frequency and severity of other health problems such as TB, hepatitis, human immunodeficiency virus/acquired immunodeficiency syndrome, and other sexually transmitted diseases?
- What are the demographics that could affect program design (such as age, gender, ethnicity, geographic location in the jurisdiction, employment status/earning capacity, housing, and family situation)?
- Possible sources of quantitative and qualitative data to help answer these questions include

- Police departments
- Sheriff's office/jail administrator
- Pretrial services agency
- Arrestee interviews
- Court records
- Observation/breath and urine testing of arrestees
- Treatment and public health agencies
- Community anti-drug coalitions
- Single State substance abuse agency databases
- TASC or other case management agencies
- Local college and university researchers
- Other criminal justice system practitioners, prosecutors, defense lawyers, judges, probation department personnel.

Information About Existing Treatment Resources

Drug court planners need to know about the treatment resources (including detoxification facilities) that currently exist in the community, the services that are provided to specific types of clients, and the gaps that exist in provision of services.

Planning committee members familiar with the community's treatment system can help with this inventory, as can the office of the State Alcohol and Drug Abuse Director. Both public and private providers should be included in information-gathering efforts, and the inventory should cover ancillary services that, even though they may not be provided directly by a substance abuse treatment professional, are important for addressing client needs. The planning committee can poll the treatment community by sending a questionnaire to all community providers asking, among other things, what type of services they provide and how willing they are to work with clients in new ways. Responses to the questionnaire help determine interest as well as a compile an inventory of providers.

The committee should clearly identify the size, philosophy, and special characteristics of every existing substance abuse treatment program in the jurisdiction. Some treatment providers may already have specific services in place that would provide a good match for potential target populations drawn from the pool of pretrial defendants. For example, special programs may already exist for women with substance abuse problems.

From a political or criminal justice viewpoint, it is possible that the public health activities in which some treatment providers participate could exclude them from participation in a pretrial drug treatment program. For example, some providers might espouse or operate needle exchange programs that could generate negative publicity or strong community objections. While no hard and fast rules for inclusion or exclusion exist, the planning committee must know the operating philosophies and treatment modalities of each treatment provider in order to anticipate problems.

In addition to developing descriptions of each substance abuse treatment provider's programs and philosophies, the planning committee should also inventory the extent to which other services commonly needed for effective substance abuse treatment are available. Research and clinical experience have shown that treatment is most effective when coupled with other interventions

that address the full range of client needs. The availability of such ancillary services enables the client to benefit more fully from treatment.

Substance abuse treatment clients are likely to have needs and deficits in one or more of the following areas:

- Education
- Literacy skills
- Life skills (such as parenting)
- Physical and mental health
- Housing
- Vocational training
- Employment
- Child care
- Specific cultural/gender needs
- Legal problems (for example, eviction from housing or suspension or revocation of a driver's license)
- Transportation
- Domestic violence.

In conducting an inventory of programs and services that can supplement the needs of clients in these areas, the planning committee can obtain assistance from substance abuse treatment providers. Treatment providers are increasingly sensitive to the need for these services and can usually provide lists of available community resources. Members of the planning committee who are affiliated with educational organizations and social services agencies can also help identify these resources.

Information About Legal Issues

In the initial planning stages, there are three types of legal issues about which planners need information:

- **To what extent, and in what ways, do existing laws, regulations, and authoritative court decisions either constrain or facilitate program design?** For example, is there existing legal authority, either in statute or in court rule, for judges to refer defendants to a treatment program or to make urine testing and participation in a substance abuse treatment program conditions of pretrial release? Conversely, are there any legal prohibitions against such judicial orders?
- **What laws and regulations may affect treatment providers' capacity to treat pretrial defendants and to inform the court and other justice system agencies about a client's progress (or lack of progress) in treatment?**
- **What laws and regulations may affect financing for the program, including laws governing state and local budget processes, federal grant funding, and reimbursement of treatment costs?**

Developing an understanding of the legal framework will give planners critical information about specific program design issues. Several of the key legal issues that must be addressed in

the planning, program design, and program implementation processes are discussed in Chapter 8 of this TIP.

Information About Costs

Substance abuse treatment costs money. Reorganization of the operating procedures of courts and other criminal justice agencies to link pretrial processing with substance abuse treatment is also likely to lead to additional costs. Examples of new resources that may be needed include additional staff (to perform functions not previously performed) and new computer equipment to produce the information needed for case decision-making, program monitoring, and evaluation.

The planning committee must have reliable information about all of the costs to be incurred in implementing the program. Optimally, the committee will have information on costs at different levels of operation, from the time of an initial pilot to full-scale operation. The committee should examine what sources of funding are available, both for initial program operations and for ongoing operations if the program proves successful. The committee should also seek to identify the benefits of treatment, both to the community and to the defendant. If possible, estimates of the economic value of these benefits should be developed. Chapter 7 of this TIP discusses cost and financing issues in more detail.

Determining the Target Population and Possible Points of Intervention

Once the planning committee has developed basic information about the pool of eligible defendants and the treatment resources available, decisions can be made about what categories of defendants will comprise the *target population* for the program. The size and makeup of the pool of potentially eligible defendants, program costs, politics, and community standards and values are among the factors that must be considered in deciding on a target population.

Drug courts have varied considerably in their choice of target groups. Although some handle only drug possession cases, some accept defendants charged of a much wider range of offenses (usually nonviolent) when the criminal behavior appears to be driven by a substance abuse problem.

Jurisdictions that have started drug courts have varied considerably in their choice of target groups.

Generally, drug courts have excluded defendants charged with sale or trafficking of drugs unless they played a minor role in distribution and an underlying addiction is clearly driving their participation in drug selling. The Superior Court Drug Intervention Project in Washington, D.C., is one of the exceptions: Any felony drug defendant on pretrial release is eligible to participate, regardless of conviction record. (Violent felony defendants, of course, would normally be in detention and would not be in the eligible pool.) The drug court in Portland, Oregon, also accepts defendants with extensive criminal records, including violent offenders, but excludes those

charged with drug sales or trafficking. (Note, however, that federal funds are not used for interventions with violent offenders in accord with federal policy.)

Decisions about target group composition will be based in part on what kinds of cases are acceptable from a political standpoint and in part on the needs of the potential target population and the availability of treatment resources. With information about the size and makeup of the potentially eligible groups of defendants, their treatment needs, and existing treatment resources, the planning committee can project the size of the program and the characteristics of the potential participants. Such a projection will help the committee assess the range of needed services and develop criteria for participant selection and treatment services. If the target population is clearly too large or too small, further refinements in the definition of the target group will be required.

Target populations will vary depending on the stages in the process at which the treatment intervention is sought. In general, the earlier in the process the intervention is made, the stronger the rationale for targeting defendants whose current charges and prior records indicate no history of violent offenses or significant drug trafficking. The more serious the current offense and prior record, the greater the likelihood that pretrial and case management staff will want additional information about the defendant's criminal activity and substance abuse. While these defendants may not be automatically excluded from a pretrial drug treatment program, it may be appropriate to ensure that the treatment take place in a secure setting (possibly including jail) or to set conditions that include close supervision while the defendant is on pretrial release.

Selecting Treatment Providers and Programs

It is pointless to target a specific population for a drug court program if appropriate treatment resources are not available or cannot be developed. The planning committee should carefully consider the resources of the substance abuse treatment system in the community and work closely with the community to design a set of realistic treatment options.

The planning committee's inventory of treatment providers and ancillary services, coupled with an analysis of the target group's treatment needs and information about treatment costs, should provide the basic information necessary to select a primary treatment provider or a network of providers. Sometimes, no existing program in the community will meet the needs of the target population. Under these circumstances, it may be necessary to negotiate with existing providers to modify their services or create new ones. Conceivably, it may even be necessary to ask treatment providers outside the locality to expand their services.

Creating Memorandum of Understanding

Initial agreements, in the form of a Memorandum of Understanding (MOU), is another critical part of the planning process. The MOU should set forth the goals of the program and should include commitments from all the key stakeholders and planning committee members. The memorandum is contractual in nature and should spell out, to the extent possible, the composition of the target group and the anticipated contributions and responsibilities of each stakeholder that is a party to it.

Development of the MOU is a key transition point from initial planning stage to actual program design. While the contents of a MOU will vary from one jurisdiction to another, essential elements of it should include at least the following:

- A description of program goals
- A description of the target group
- A description of program services to be provided, and how and by whom they will be provided, including
    - Screening
    - Assessment
    - Detoxification
    - Case management
    - Substance abuse treatment
    - Ancillary services.
- A description of program organization and management, including the identity of individuals who will have primary responsibility for program operations within the justice, case management, and treatment systems
- A description of the management information system reports that will be available to support program operations, and the provisions for cross-system exchange of information
- A summary of key measures of program performance to be used for monitoring and evaluation, with sources of relevant data indicated
- A budget showing anticipated expenses and sources of revenue for all program components
- Approvals by the key stakeholders, indicating their commitment to the plan developed thus far
- A description of the processes to be followed in program review and evaluation and in amending the MOU as necessary.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
Treatment Improvement Protocol (TIP) Series 23

Chapter 4 -- Designing the Program

The general policies and plans developed during the initial planning stage must eventually be shaped into a design for a fully operational drug court. This chapter focuses on nine key issues that must be addressed during the design stage:

- Screening
- Assessment
- Determining categories of care and components of treatment
- Detoxification practices
- Program admission criteria and procedures
- "Relapse" policies and judicial supervision of the defendant's progress in treatment
- Staffing and cross-system liaison
- Management of information
- Program monitoring.

Screening

Screening is a process used to determine whether an individual is a likely candidate for participation in a treatment program or needs other types of attention. Typically, a program that links substance abuse treatment with pretrial case processing will be limited to defendants who meet certain criteria with respect to the nature of their substance abuse problems, the current charges pending, and their criminal records.

Screening has three purposes:

- To identify individuals who have substance abuse problems that may warrant treatment
- To identify individuals who have infectious diseases
- To identify individuals who fit within the target population of the program in terms of criminal justice criteria.

It is important to recognize that substance abuse and infectious disease screening is not the same as a comprehensive assessment. Screening is done quickly, using relatively simple instruments and methods. A screening instrument does not provide enough information for a clinical diagnosis; rather, it indicates the *probability* that a particular condition, say, chronic alcohol

abuse or TB or a STD, is present. The goal of screening is to quickly identify potential candidates for treatment intervention.

It is important to recognize that screening is not the same as a comprehensive assessment.

Criminal justice screening serves different purposes. Its principal function is to determine the defendant's eligibility for pretrial release or diversion programs linked to substance abuse treatment. Ideally, screening in all three areas, for substance abuse treatment, for infectious disease, and for criminal justice program eligibility, will take place within 24 hours of the defendant's arrest.

Screening for Substance Abuse

Substance abuse screening is a preliminary gathering of information to determine if an individual has a problem with substance abuse and, if so, whether a comprehensive clinical assessment is appropriate. Personnel doing the screening do not have to be social services professionals, but effective screening does require training. The screening can be done quickly (no longer than 20 minutes) with standard screening instruments. The substance abuse screening process typically involves eliciting responses to questions in five areas:

- **Consumption patterns** -- the frequency, duration, and quantity of substance abuse
- **Feelings of loss of control** related to substance abuse
- Extent of **physical consequences** of substance abuse
- Experience with **physiological problems** related to withdrawal from substance abuse
- The individual's **recognition** of problems related to substance abuse.

In addition to interviews or self-administered screening instruments, screening should also include urinalysis, observation of physical signs (such as obvious inebriation or needle tracks) and a review of the individual's criminal history to see if it includes drug use or possession.

The most common substance abuse screening instruments used in treatment programs in the criminal justice system are

- The CAGE questionnaire
- Short Michigan Alcohol Screening Test
- Substance Abuse Screening Instrument
- Offender Profile Index
- AIDS Initial Assessment Jail Supplement
- SALCE (Substance Abuse Life Circumstances Evaluation).

Most of these instruments are described and included as Appendix C in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse in the Criminal Justice System* (CSAT, 1994a).

There are not as many screening instruments for infectious disease as for substance abuse, but CSAT has developed a prototype infectious disease screening instrument that can be used in conjunction with substance abuse screening.

Screening for Infectious Diseases

There are not as many screening instruments for infectious diseases as for substance abuse, but the Center for Substance Abuse Treatment (CSAT) has developed a prototype infectious disease screening instrument that can be used in conjunction with substance abuse screening. Designed primarily to help identify individuals who may have infectious diseases that are significant public health problems (especially TB, HIV/AIDS, and STDs), the instrument can be administered in about 15 minutes. The results can be used both to help determine suitability for participation in a court-linked substance abuse treatment program and as a basis for referral to a health care facility for further infectious disease assessment and treatment (regardless of whether the defendant enters the substance abuse treatment programs). The prototype instrument is described in detail in TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (1994c). However, elements of the prototype instruments can be used for making an assessment about defendants' STD risk. TIP 6, *Screening for Infectious Diseases Among Substance Abusers* (CSAT, 1993b) can also be useful to planners.

Screening for Criminal Justice Program Eligibility

Eligibility screening for a treatment program linked to pretrial case processing necessarily involves attention to not only to the current charge but also to the defendant's prior criminal history. Often, the criteria for admission to a program will be restricted to defendants facing only particular types of charges, for example, drug possession or driving under the influence. Admission to a program may also be restricted to individuals with no past convictions for violent offenses and no currently pending charges involving violence. Sometimes programs may exclude individuals currently on probation or parole.

Screening related to criminal justice eligibility ordinarily involves examination of arrest and complaint papers relating to the current charge and review of criminal history data available through local, State, and sometimes national criminal records repositories. It may also involve an interview with the defendant and contacts with the defendant's family or others in the community to determine whether or not the defendant has a place to live if released from custody.

Personnel Responsible for Screening

Screening personnel do not need to be highly trained social service professionals. It is important, however, that substance abuse treatment professionals or criminal justice program staff responsible for screening functions be well trained in the use of screening instruments and other methods of identifying substance abuse problems and risk factors for infectious diseases.

Criminal justice personnel can be trained to do some or all of the initial screening. Optimally, the screening will be done before the defendant's initial court appearance. Personnel from any of the following agencies (or a combination of them) can do the screening:

- The law enforcement agency that makes the initial arrest and does the booking
- The sheriff's department or other agency in charge of the jail
- A pretrial services agency
- A TASC (Treatment Alternatives to Street Crime) agency that works with the court
- A newly created drug court program agency.

Criminal justice personnel can be trained to do some or all of the initial screening.

Interviews with a defendant about substance abuse and infectious diseases should be accompanied by a clear explanation of the purposes of the interview, the defendant's rights regarding confidentiality, and any limits on the confidentiality of information obtained through the interview. The screening interviews should be conducted in private, preferably by non-uniformed persons trained in cultural competency as well as in substance abuse and infectious disease screening methods. Screeners should be supervised by program managers to ensure consistency and quality, and to make sure that they are aware of the program's current eligibility and suitability criteria.

Assessment

Assessment for Substance Abuse Treatment

While screening is focused on program eligibility and on potential substance abuse and infectious disease problems, assessment is a more comprehensive set of procedures, intended to confirm or refute the results of the initial screening, identify the specific substance being abused , any coexisting health problems -- particularly mental health disorders -- and begin formulating a treatment plan. For more information on coexisting mental illness and substance abuse disorders, see TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994b). One assessment instrument used by substance abuse treatment professionals is the Addiction Severity Index (ASI), which must be administered by a clinician and takes an hour. The assessor develops and analyzes information about the nature and extent of the defendant's substance abuse history, mental and physical health problems, social and economic status, and readiness for treatment. The types of treatment and ancillary services required to address the problems are then identified.

Components of an Assessment

A comprehensive assessment for substance abuse treatment is a thorough evaluation of the individual, using multiple procedures and sources of information, to establish the presence or absence of a diagnosable disorder or disease and lay the clinical foundation for treatment.

Ordinarily, a clinical assessment addresses issues in three broad domains of an individual's life: social, psychological, and medical. Each of these domains includes a number of specific components.

Elements to assess in the social domain include

- **History of substance abuse**, including drugs used, frequency and pattern of use, previous treatment, and drug-using patterns in the family
- **Involvement with the criminal justice system**, including prior criminal history and any pending charges
- **Family history and social roles**, including the individual's roles in the immediate and extended family, as well as employment status
- **Educational and vocational** needs
- **Employment and salary history** (socioeconomic status)
- Spirituality, including the offender's sense of community and "sense of belonging in the universe"
- Experiences with **domestic violence and child abuse/neglect**.

Components of the psychological domain include

- Level of **psychological development**
- Levels of **anxiety and depression**
- Risk of and/or history of prior **treatment for mental illness**
- Use of any **medication** for mental health purposes
- Presence of **personality disorders** or other mental disorders
- **Central nervous system** function and impairment
- History of **sexual, emotional, and/or physical abuse**
- History of **violent behavior**.

Areas to assess in the medical domain include

- Risk of and/or history of **infectious and contagious diseases**, including HIV, hepatitis, STDs, and TB
- **Medical problems**, including nutritional deprivation, and dental problems. A medical examination should be conducted to determine health status. Tests for the presence of infectious diseases also should be conducted.

Program personnel must follow State and local laws and regulations when developing assessment questions concerning health issues. In some States, for example, asking questions about HIV/AIDS status is illegal or subject to laws and regulations concerning confidentiality. On the other hand, some states, such as Arizona, require that injection drug users be tested for HIV.

The information gathered usually is written up as a summary statement that integrates the information acquired, the diagnostic impressions of the assessor, and the recommendations for treatment.

Personnel Responsible for Assessment

Unlike screening, assessment requires substantial experience in clinical settings. Ordinarily, the person doing the assessment should have a master's degree and clinical experience. Psychologists, social workers, certified addictions counselors, and clinical nurses are among those qualified to administer the psychological and sociobehavioral parts of the assessment. The biomedical portion of the assessment is usually best performed by a health professional with training in diagnostic skills, such as a physician, nurse, or physician's assistant.

The justice system in the jurisdiction may already have personnel who can conduct portions or perhaps all of a clinical assessment. For example, some pretrial service agencies, TASC programs, probation departments, and local jails have social services and health professionals on staff who are qualified for this work. In addition to an appropriate educational and clinical background, staff responsible for the assessment should be culturally competent and should have skills in establishing rapport with the defendant; maintaining a nonjudgmental, nonthreatening attitude; and succinctly documenting information.

Timing of an Assessment

An assessment should follow arrest as quickly as possible -- a primary treatment objective is to take advantage of this crisis in a substance abuser's life. Further, judges and prosecutors are concerned about the expeditious processing of cases. If a defendant is to be considered for deferral of prosecution and placement in treatment, information about his or her treatment needs must be readily available.

One of the primary objectives of these programs is to take advantage of the crisis in a person's life typically caused by an arrest.

As a rough standard, many jurisdictions that have developed drug courts in recent years attempt to place eligible defendants in treatment 1 to 2 days following arrest. However, in order to provide effective treatment services, a longer period may be needed for a complete assessment. The scope and timing of the assessment are critical issues in the design of a drug court program, and should be a subject of discussion and negotiation among the treatment providers and justice system leaders. It may be possible to develop a two-stage assessment process, an initial step that provides information needed by the court for its basic decision about referral to treatment (more than initial screening; less than full-scale assessment), and a second stage that provides more complete information, enough for the treatment provider to make a specific referral and for the court to monitor the defendant's performance in treatment.

Assessment Instruments

The treatment field uses numerous questionnaires and instruments to collect information from the substance user. Two of the best known are the

- **Addiction Severity Index (ASI)**, which requires about 60 minutes to administer and is available from the National Institute on Drug Abuse.
- **Wisconsin Uniform Substance Abuse Screening Battery**, which requires a fee for use, but which provides comprehensive data.

The Fifth edition of the ASI is reprinted in TIP 7, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* (CSAT, 1994a), which also includes instruments for assessing AIDS risk and for determining the appropriate type of substance abuse treatment. That TIP also describes a number of other instruments used for assessment.

All assessment questionnaires have strengths and weaknesses, and treatment professionals' preferences are based on particulars from clients' situations to communities' needs. Many programs cobble together parts of various instruments.

One way to select an assessment instrument or group of instruments is to form a focus group of local treatment professionals who understand the target population and the cultures of individuals who routinely come before the court to select the treatment instrument(s). Culture-specific instruments should be reviewed by people knowledgeable about the culture to ensure that the questionnaires ask the target group the right questions and are not skewed to misinterpret behaviors of minority cultures as aberrant. Instruments should be translated into the language of the population(s) being assessed.

How Are the Results of an Assessment Used?

At each stage in the processing of criminal defendants, those doing the screening and assessments must balance the *risk to public safety* against the *treatment needs* of the client. This risk/needs assessment should be incorporated into a mutually reinforcing supervision and treatment plan. That plan should include incentives and graduated sanctions as part of supervision as well as treatment interventions and social services that constitute a continuum of care.

The assessment should lead to a diagnosis of the extent and severity of addiction and the problems it has created in the individual's life. It should also lead to a treatment plan, agreed to by the treatment provider and the individual and approved by the court, that states specific goals for recovery and outlines steps to begin and maintain the recovery process.

Judges and other justice system officials will need to know all recommendations made regarding the proposed plan of treatment based on the results of the assessment. If the assessment is conducted in two stages, as discussed above, the justice system officials must review the results of both. The results of the first, more cursory stage will help a court decide whether to place the

defendant in a treatment program. The second part will guide the choice of conditions the defendant must meet. Judges, prosecutors, and the defendant's own lawyer need to know what goals and objectives have been set for the treatment plan, how they are to be measured, and when and how they will receive information about the defendant's performance in treatment.

Determining Categories of Care and Components of Treatment

In designing a drug court program, planners must make difficult decisions about the types of services that will be available through the treatment program, and about where, when, by whom, and for how long these services will be provided for the target population. Because substance-abusing populations and treatment resources that are available (or that can, realistically, be developed) vary widely from jurisdiction to jurisdiction, each is likely to develop its own approach. This section provides general information on categories of care and treatment modalities that are widely (although not universally) available. It is up to the program planners in each jurisdiction to decide what categories of care and treatment modalities and services make sense for the target population.

Categories of Care

Substance abuse treatment services range across a continuum that comprises three major categories of care: pretreatment services (education/prevention); outpatient treatment; and inpatient treatment (including residential treatment).

Pretreatment Services

Pretreatment services include primary prevention (for those who have not yet abused alcohol and other drugs) and early intervention (for people who have begun to abuse alcohol and other drugs and are considered to be at high risk for developing problems related to use). Pretreatment services are *not* part of primary treatment. They typically consist of psychoeducational services designed to increase individuals' awareness of the dangers of substance abuse.

Outpatient Treatment

This is the most common form of substance abuse treatment, including both 1/2- to 1-hour individual sessions and intensive day treatment centers. Outpatient treatment has advantages over inpatient or residential treatment (for clients who are not in need of acute care) in that the client can maintain or seek employment, remain with family, and maintain contact in the community during the treatment process. Types of outpatient treatment include

- Non-intensive outpatient treatment
- Intensive outpatient treatment
- Opioid substitution therapy
- Day treatment, partial hospitalization, or day reporting centers.

Inpatient Treatment

This type of care can be provided in a hospital or medical facility (for those with the most acute treatment needs), or in a wide range of other types of therapeutic residential settings, such as apartments, dormitories, and supported housing. The residential programs may be secure or non-secure facilities, and the length of stay and costs of treatment can vary considerably. Types of inpatient treatment programs include the following:

- Medically managed intensive inpatient treatment (hospital-based)
- Short-term non-hospital intensive residential treatment (hospital-based)
- Intensive residential treatment
- Psychosocial residential care
- Therapeutic community
- Halfway house
- Group home living.

Length of treatment is an issue closely related to the category of care. To a significant extent, the length of treatment offered by many providers has been shaped by insurance companies' policies concerning payment for treatment services. For example, insurance companies have commonly used a standard of 28 days for reimbursable residential treatment, and many private treatment providers have designed 28-day residential programs. The needs of the pretrial defendant target population, however, will seldom fit the 28-day model. Recent research has verified that clients in a criminal lifestyle that includes substance abuse need a *minimum* 90-day treatment intervention to change their behavior. Most treatment drug courts provide for at least six months of supervision and treatment services. Justice system officials and substance treatment providers together should develop cost-effective programs that can meet the needs (and limitations) of the target population, the justice system, and the treatment community.

Detoxification Practices

Detoxification is the process through which a person who is physically dependent on alcohol, illegal drugs, prescription medications, or a combination of these drugs undergoes medically supervised withdrawal from the drug or drugs of dependence. Detoxification is an important part of the treatment process, because it is difficult to properly assess an individual or provide treatment for the underlying substance abuse if the individual is inebriated or in the early stages of withdrawal. In severe cases of dependency or withdrawal, the individual may be unresponsive to questions. Detoxification stabilizes chemically dependent defendants and allows them to move on to the next step in their recovery.

Dade County has used existing hospitals while building its own detoxification services for outpatient use.

Withdrawal symptoms can range from mild discomfort to acute, even life-threatening symptoms such as convulsions, hallucinations, suicidal ideation, and severe depression. Medication can

reduce some of the discomforts of withdrawal and minimize medical complications. Blood pressure monitoring and medical supervision may be required, depending on the drugs used by the defendant and the clinical symptoms of withdrawal. TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995), provides guidelines for safe, medically managed withdrawal.

Some jurisdictions, such as Dade County, Florida, have used existing services such as hospitals while building their own detoxification services for outpatient use. In addition, jail detoxification and treatment programs have been used to treat more difficult cases. Once the unique needs of substance-abusing offenders are identified, many programs have tailored their detoxification procedures to fit client needs.

Many communities have detoxification centers, either in a criminal justice or social services environment, that are supervised by a nurse and have a physician on call. Some hospitals, both public and private, have detoxification units that range in duration and intensity from short-term to long-term programs.

From a program design standpoint, there are several key questions that must be addressed with respect to detoxification:

- What agency or agencies will provide detoxification services for arrested defendants? Are different approaches and facilities needed depending on (a) security/custody needs with respect to the defendant; and/or (b) the level of substance abuse and probable severity of the withdrawal?
- How can screening procedures be used to help identify the detoxification needs of defendants?
- How and when will defendants needing detoxification services be transported to the appropriate detoxification facility?
- What specific detoxification services will be provided? By whom? For what period of time and at what cost?

In addition to traditional withdrawal methods, *acupuncture*, an approach taken from Eastern medicine, is now being used as an adjunct to assist in the detoxification process in some jurisdictions. Several research studies have indicated that acupuncture can be effective in reducing cravings and in ameliorating withdrawal symptoms. The first court-linked program to extensively use acupuncture was in Miami, Florida. Acupuncture is now an integral part of court programs in a number of U.S. jurisdictions.

Before introducing acupuncture as part of a drug court program, it is important to coordinate efforts with public health officials to ensure that certification requirements can be met. In California, acupuncturists are required to obtain the equivalent of a 4-year medical degree. Acupuncture is offered as an adjunct to treatment in many substance abuse treatment programs. Although full-body acupuncture requires a facility that has beds and changing rooms, it is possible to use much simpler (and less expensive) clinic style methods. Current use of acupuncture to help with detoxification generally involves a five-point auricular (ear) application. This procedure can be applied by trained technicians to clients who are sitting in chairs. This procedure is less expensive than full-body acupuncture, and a State's medical authority may certify it for use in treatment programs.

It should be noted that some substance abuse treatment professionals object to acupuncture because they see it as a hindrance to treatment. Some believe that acupuncture replaces the "needle ritual" that is part of some drug users' lives. Others say that the calming effect of acupuncture can undermine other treatment, which sometimes requires confrontational approaches.

In designing a court-linked substance abuse treatment program, planners should consider what role , if any, acupuncture should play and what safeguards are needed to ensure that acupuncture procedures are appropriately and safely used.

Planners may also want to consider detoxification approaches that are culture-specific. For example, Native Americans use sweat lodges for a variety of ritualistic and social purposes. Assignment to a sweat lodge may be appropriate action to take for Native Americans who do not exhibit life-threatening symptoms, provided they meet other criteria of program eligibility. Latinos and Hispanics may also use herbalists and "curanderos" who treat withdrawal symptoms with traditional remedies. Although the efficacy of such culturally based methods of detoxification is not yet fully documented by researchers, the psychological and social benefits to the individual who believes in these traditions may be considerable.

The Components of Treatment

Most treatment providers offer a range of treatment services. It is important to remember that not all programs will provide all services and that the level and focus of services provided may vary widely from program to program. However, services generally include

- **Evaluation and assessments**: medical, psychiatric, and substance use assessments
- **Treatment planning**: medical, psychiatric, and addiction treatment planning
- **Counseling/therapy**: group therapy, individual counseling, family therapy
- **Medical assessment and treatment**, including attention to HIV/AIDS, hepatitis, TB, and STDs
- **HIV/AIDS** education, testing, and counseling
- **Comprehensive pregnancy care**: prenatal care, parenting classes, childbirth classes
- **Mental health services**, including medications when indicated
- **Education about substance abuse**: lectures, interactive groups, videos, reading assignments, journal and writing assignments
- **Self-help** education and support, including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)
- Social and other **support services** for the offender and family members
- **Relapse prevention** services
- **Substance abuse treatment services** to family members and significant others
- **Acupuncture** and other nontraditional detoxification and healing techniques
- Services for **special populations**, such as violent offenders, incest survivors, incest perpetrators, and those with dual disorders.

In addition, the treatment provider usually tries to link the client with a variety of ancillary services to address other problems. These may include

- Education, including basic reading and math skills
- Job training and counseling
- Housing
- Child care
- Nutrition assistance.

Treatment providers increasingly note that many clients require "habilitation," not simply "rehabilitation." In other words, some addicted persons have not lost functional capacities and skills as a result of their addiction but have, in fact, never acquired them. Many persons, for example, have not acquired the capacity to control impulses or to distinguish between emotional states. Some lack the skills to sustain day-to-day relationships with others, or suffer from Attention Deficit Disorder. The fact that more and more clients suffer from a lack of basic capabilities and skills makes the treatment of the underlying addiction more difficult.

Treatment providers increasingly note that many clients require "habilitation," not simply "rehabilitation."

Aftercare

Components of aftercare in treatment programs typically include

- Random drug testing
- Self-help groups (AA, NA)
- Acupuncture (in some jurisdictions)
- Group counseling
- Individual counseling
- Employment
- Education
- Mentoring
- Strengthening family and community ties.

Aftercare is a critical component of treatment. Even when an individual has completed a treatment program satisfactorily, the danger of relapse remains. This is especially true when the client returns to the community after time in a residential program and is confronted by the conditions (including friends), that promoted substance abuse before treatment. In designing a drug court program, it is important to devise aftercare services in which the client has routine access to self-help groups and counseling sessions.

Culturally Specific Treatment Programs

The last decade has seen much greater attention paid to the role of each client's culture in the treatment process. Because treatment is so intense and stressful, it is preferable for clients to obtain services not only in their native language but sensitive to their culture's patterns of beliefs, feelings, and behaviors. For example, Western cultures tend to stress individualism and self-control, and clients from more family-centered cultures respond better to a family-oriented approach to treatment. In traditional Western cultures, introspective discussion of one's personality and behavior in a group setting is not uncommon, but such self-disclosure is utterly foreign in some other cultures. The best treatment programs take their clients' cultural backgrounds into account.

Both substance abuse treatment and criminal justice professionals often fail to appreciate the great diversity among the immigrant groups in the United States. For example, Spanish-speaking cultures are treated as one "Hispanic" entity, even though Mexican, Puerto Rican, Cuban, and Central American cultures differ significantly from one another. It is very important for criminal justice-based treatment programs to be sensitive to these and other areas of diversity, and to make certain that treatment resources include programs for the principal ethnic and racial minorities in their jurisdictions.

Program Admission Criteria and Procedures

There is a discussion in Chapter 3 of issues regarding the target population and possible points of intervention. During the program design stage, initial plans concerning these issues must be translated into decisions about the types of defendants who will be eligible for the program, what information and advice these defendants will be given concerning possible participation in the program, and when and how participants will be selected.

The issues of eligibility and suitability relate directly to the screening function discussed at the start of this chapter, and, more broadly, to the overall goals of the program. In the design stage, the program goals, together with the planners' knowledge about treatment resources that are available or can be developed, should help shape the criteria for admission to the program.

In general, jurisdictions that have initiated treatment programs for pretrial defendants begin by targeting those regarded as relatively low-risk offenders in terms of public safety considerations. For example, defendants with a history of committing violent offenses are often not eligible for a treatment program even if their current charge is a nonviolent one (such as possession of an illicit drug). In some places, as programs have gained experience and developed credibility with the public and with justice system officials, the eligibility criteria have been expanded to include a broader range of defendants.

Examples of eligibility criteria used by drug court programs include

- **Current charge of purchase or possession of a small quantity of illegal drugs**; may also include possession with intent to sell or distribute

- **Current charge of another nonviolent offense** (for example; theft, forgery, passing worthless checks, prostitution, or burglary), committed while under the influence of drugs or alcohol
- **Current charge of operating a motor vehicle while intoxicated** or under the influence of drugs or alcohol
- **History of substance abuse** problems, including recent abuse
- **Criminal history** that does not include conviction of a felony crime or violence
- **Willingness to participate in a treatment program**, having been informed of the conditions of participation.

In the design stage, the program goals, together with the planners' knowledge about treatment resources that are available or can be developed, should help shape the criteria for admission to the program.

Suitability criteria are more difficult to apply. It is clear that there are some situations in which, although technically meeting the eligibility criteria, the defendant is unlikely to benefit from the program, may disrupt program activities, or may need medical attention before being considered for admission to the program. Examples of categories of defendants often not accepted into a program include drug traffickers and dealers; defendants who have severe psychological problems (e.g., persons who may be receiving psychiatric medication but are not stabilized on their medication); and defendants with medical conditions that require immediate attention.

Establishing clear criteria for admission to the program is a critical first step. With these criteria in place, the design team can develop additional procedures for identifying defendants who are both eligible and suitable for admission to the program. Because jurisdictions organize post-arrest case processing in different ways and have differing legal requirements concerning issues such as speedy trial rights, appointment or assignment of counsel, and use of deferred prosecution or deferred judgment, there is no single sequence of events that is appropriate for every jurisdiction. However, the design team in any jurisdiction should be prepared to address the following questions:

- **Who (what agency or agencies and what individuals) will conduct the initial screening** for criminal justice charges and prior history, substance abuse, and infectious disease problems? Where will this be done? What access will the screeners have to criminal history information?
- **Who will be responsible for informing the defendant** about the possibility of participating in a treatment program? When will this be done? What information will be provided to the defendant at this time?
- **At what stage will the defendant have the opportunity to consult with defense counsel** concerning the possibility of participating in the treatment program? What information will the defendant and defense counsel have at that point, concerning the current charges against the defendant and the duration and conditions of participation in the program?
- **What are the potential benefits to the defendant** from "successful" participation in the program (e.g., dismissal of charges; vacating of plea or conviction)?

- **What rights, if any, will the defendant have to waive or relinquish** in order to participate in the program? Will a plea of guilty, or agreement to stipulated facts, be required as a condition of participation?
- **How much time will the defendant have to consider the possibility of participating** in the program? Regardless of the defendant's initial decision, will there be an opportunity for reconsideration?
- **How will the court, the prosecutor, the defense counsel and the defendant know if there is an open "slot**" in a treatment program appropriate for the defendant?
- **What role does the treatment provider have in the initial decision** to admit the defendant to the program? How will this vary if the program uses multiple providers?
- **What role does the prosecutor have in the initial decision** concerning admission of the defendant to the program?
- **How soon after the initial arrest does the judge consider the defendant's admission to the program?** What information and recommendations will the judge have at that point? From what sources?
- **What is the range of options available to the judge** concerning admission of the defendant to the treatment program and establishment of conditions for participating in the program? What conditions will usually be imposed and what factors control their imposition? To what extent, and how, will urine testing be used as a condition of program participation?
- **When will treatment begin** once a defendant is admitted to the treatment program?

Every jurisdiction that has established treatment programs linked to pretrial case processing has answered these questions in its own way.

"Relapse" Policies and Judicial Supervision of the Defendant's Progress in Treatment

One of the hallmarks of the newer drug court programs is a strong emphasis on active judicial oversight of the defendant's performance in the treatment program.

The Judge's Supervisory Role

The judge will generally require the defendant to appear at regularly scheduled status hearings, at which the defendant's treatment progress is reviewed. While patterns vary from court to court, the status hearings may be held as often as once a week during the first month or so. As treatment progresses (and especially if the defendant appears to be making satisfactory progress), the frequency of the status hearings decreases, but the court continues to monitor the defendant's performance.

At the status hearing, the judge reviews reports from the case manager or treatment provider and possibly from other parties that have a role in the treatment process. Topics covered at the hearing ordinarily include

- Substance use test results (e.g., urinalysis)
- Report on defendant's attendance at treatment sessions

- Report on defendant's attitude toward treatment, including recognition of the substance abuse problem.

In addition to these substance abuse and treatment-specific topics, the judge may also inquire about other aspects of the defendant's life, including housing, work, family, and general health. The judge can thereby develop rapport with the defendant and support the defendant's efforts to overcome the substance abuse problems.

Developing Participant Accountability

One key aspect of judicial supervision of the defendant's performance in treatment is the use of sanctions when a defendant fails to comply with program conditions and rewards for continued abstinence. The ways in which sanctions and rewards are used varies considerably from jurisdiction to jurisdiction, but their use reflects an orientation very different from the traditional response of the court to substance-abusing offenders.

Traditionally, if a defendant was caught using alcohol or drugs in violation of conditions of probation, his or her probation was revoked. By contrast, programs that integrate substance abuse treatment with pretrial case processing deal with renewed use of alcohol or other drugs as part of the recovery process.

Most individuals with severe substance abuse problems have few coping skills to help them deal with situations where they are tempted to use alcohol or drugs. "**Relapse**" (sometimes called "backsliding") is common. Indeed, many substance abusing individuals relapse and return to treatment several times before achieving abstinence from alcohol or drugs for any appreciable duration. But the fact that relapse is common does not mean that it is ignored. On the contrary, one of the functions of the judge in an integrated program is to take appropriate action to reinforce the treatment program.

A treatment report that presents evidence of relapse (for example, a succession of positive urinalyses for drugs for a drug-using defendant; failure to attend treatment sessions) is a signal to the court that the treatment plan needs to be reviewed and that some type of sanction is probably needed. Sometimes a verbal admonition by the judge is all that is needed. At other times, it may be necessary to increase the frequency of urine testing and counseling sessions, or to schedule more frequent status review hearings. If these approaches don't work, it may be appropriate to place the defendant in jail or a community correction facility, perhaps increasing the duration of imprisonment at each violation.

Jurisdictions vary considerably in the policies they follow in responding to noncompliance with program conditions. The main point is to ensure that there are consequences for noncompliance, and that they are imposed fairly and consistently.

When defendants perform well in treatment, there should be some recognition and reward for their progress. One obvious reward is the dismissal or lessening of charges upon successful completion of the treatment program. It also helps to acknowledge progress along the way -- even modest progress. For example, a succession of negative urinalyses for drugs and regular

attendance at treatment sessions can be publicly acknowledged by the court at a status review hearing. Such progress can also be rewarded by reducing the frequency of status hearings or the intensity of the treatment program. Some programs conduct a graduation ceremony and award certificates when defendants successfully complete treatment.

Staffing and Cross-System Liaison

Staffing for an integrated program requires teamwork across agencies and institutions that generally have little history of working collaboratively. As noted earlier, this new team needs to develop a plan that ensures client accountability through a balance of supervision and graduated sanctions and treatment interventions. Those elements should be seen as mutually reinforcing.

For justice system members of the integrated program team, involvement in the program means shifting their primary focus from the guilt or innocence of the defendant to effective interventions for defendants admitted to the program.

Optimally, members of the program team for the pilot or startup phase of the program will have had some involvement in the initial planning and in the detailed design of the program. Planning and designing the program will give team members a basic core of knowledge about substance abuse treatment and will familiarize them with the approaches and techniques used in other jurisdictions. While the composition of the teams and the precise roles and responsibilities of each team member will vary, it is possible to identify some important court-based roles and functions that will be common to most integrated programs:

The Judge

The judge will play a central role in the program. Generally, the judge will explain the defendant's legal rights and options and the program requirements at the defendant's first court appearance and right before admission to the program. The judge will also review treatment progress reports and discuss progress directly with the defendant at status hearings.

The Prosecutor

The prosecutor will generally ensure that program participants meet the established admissions criteria; will review treatment progress reports and ask the judge to impose sanctions if the defendant fails to comply with program requirements; and may seek to remove from the program participants whose treatment reports show no progress or who are arrested again for some kinds of criminal conduct.

The Defense Attorney

The defense attorney will review the charges against the defendant as well as any information available from police reports or other documents disclosed by the prosecutor; will advise defendants about their constitutional rights (e.g., right to counsel, right to speedy trial) and practical options, including participation in the treatment program; will explain how various treatment program outcomes will affect the disposition of the case; and, if a defendant opts to

participate in the program, will encourage and support the defendant's participation and compliance with program conditions.

The Screening Officer

A screening officer, who may be a pretrial services officer, TASC program coordinator, a member of the jail administrator's staff, or the incumbent of a newly created position, will be expected to review the list of defendants arrested each day, and will screen each case for program eligibility based on criminal justice criteria such as current charges and prior record. This individual may also conduct screening for substance abuse problems and infectious diseases and may supervise defendants released from custody for compliance with program conditions, including periodic urine testing.

The Court Clerk

The court clerk or court coordinator will help schedule status hearings and other court appearances; organize and prepare files for cases on each day's calendar; help the judge review the status of cases subject to judicial supervision; follow up on defendants who fail to appear in court as scheduled; and stay in regular communication with the judge, the treatment program liaison officer, and others involved in program operations.

The Assessment Officer

The assessment officer, typically an individual with master's-level training in a discipline associated with substance abuse treatment, or the equivalent in actual experience, will conduct the detailed assessment of substance abuse problems described earlier in this chapter and make recommendations concerning the appropriate category of care and type of substance abuse treatment.

The Case Manager

Case management is a term used by both the court and treatment/supervision agencies. In the court, a case manager helps the judge manage the court's pending caseload and daily calendars and acts as liaison with representatives of agencies involved in the work of the court (including treatment providers). In the treatment community, the case manager is primarily the coordinator of a team of service providers, including both treatment and ancillary services such as housing, medical care, nutrition, literacy training and job placement. In some jurisdictions, the latter function is performed by the treatment program liaison officer.

The Treatment Program Liaison Officer

This person will help explain treatment program operations to defendants who may participate in the program; will ensure that treatment progress reports are provided to the judge and to the prosecutor and defense lawyer in advance of status review hearings; will provide information on available treatment slots; and will help arrange for transportation of the defendant to the treatment program.

The titles and responsibilities of individuals participating in the program team, as well as the organizations and agencies with which they are affiliated, will vary from community to community.

This listing of staff roles is to some extent oversimplified. In actual practice there may be some revision or consolidation of roles and perhaps some additional functions. The titles and responsibilities of individuals participating in the program team, as well as the organizations and agencies with which they are affiliated, will vary from community to community.

Moreover, while there are strong arguments for beginning program operations with a relatively small and cohesive interdisciplinary team, it is important to remember that many other persons may become involved in program operations at an early date.

In a large multi-judge court, for example, it is possible that there may be more than one judge (and more than one courtroom team) involved in the integrated program. Further, it is likely that there will be some turnover in the judges and staff assigned to the program team. Optimally, the initial personnel will hold their posts long enough to establish the roles of all of the team members and regular mechanisms for communication and exchange of ideas.

Staffing for an organization that provides substance abuse treatment integrated with pretrial case processing will vary depending on the volume of cases, the categories of care provided, the components of the treatment program, and the ways in which the treatment program is linked to other social services in the community. The director or chief executive officer of any organization that provides treatment services integrated with pretrial case processing should be regarded as a member of the program team. So, too, should the counselors, case managers, and other treatment professionals who will be working with pre-trial professionals. These treatment community professionals need to understand the operation and expectations of the justice system, just as justice system professionals need to understand substance abuse treatment.

Management of Information

Information, about individual defendants and about treatment programs, is essential for the effective management of both individual cases and the overall drug court program.

On an individual case basis, information about the defendant is needed to make initial screening decisions, to do a detailed assessment of the defendant's treatment needs, and, if the defendant is admitted into the treatment program, to monitor progress in treatment, make revisions in the nature or intensity of treatment provided, and impose sanctions or reward progress when appropriate. This information is needed by the court, the treatment provider, and sometimes by the prosecutor and defense lawyer. Signed waivers and exchange of information are critical elements of the drug court operation. Some information, particularly information about the defendant's performance in treatment, may not be readily accessible unless carefully drafted

waivers of confidentiality and interagency agreements governing the exchange of information have been adopted and are used.

This is an area in which modern technology holds great potential for far more rapid and comprehensive exchange of information between treatment system and justice system agencies than would have been possible in earlier years. With automated databases in the courts and in many treatment agencies, and with the availability of electronic communications mechanisms such as e-mail and faxes, the transmission of information relevant to case monitoring and decision-making can be almost instantaneous. Some jurisdictions, such as Denver and Washington, D.C., make very effective use of online linkages between treatment providers and judges who have computers on the bench. When a defendant appears in court for a status hearing, for example, the judge can directly access information about the defendant's recent urine test results, attendance at treatment sessions, and compliance with other conditions of program participation.

With automated databases in the courts and in many treatment agencies, and with the wide availability of e-mail and faxes, the transmission of information relevant to case monitoring and decision-making can be almost instantaneous.

While many jurisdictions do not currently have such online exchanges of information, it is essential for the design team to develop mechanisms that will ensure the rapid and complete exchange of information needed -while observing the laws and regulations governing the confidentiality of information.

The categories of information needed by the justice system and by treatment providers for decision-making about individual cases are remarkably similar. They include

- **Identifiers and locators** such as name, age, sex, race/ethnicity, address, phone, fingerprint identification number, and court case number
- The **current charges** against the defendant and the facts allegedly supporting the charges
- The defendant's **criminal record**, particularly any previous convictions for offenses involving violence
- The defendant's **community ties**, including family situation, housing, and employment
- The defendant's **prior record of appearing** for scheduled court dates
- The defendant's past involvement with **substance abuse treatment**
- The **nature and severity** of the defendant's substance abuse problems
- The **nature and severity** of any medical or mental health problems
- If the defendant is admitted to the treatment program, up-to-date information on **court case status** and **performance in treatment**, including attendance at treatment sessions and results of tests for use of drugs or alcohol.

Information about individual cases and defendants, in addition to being essential for case-level decision-making, also serves a second vital purpose: providing the building blocks for effective overall program monitoring and evaluation.

Program Monitoring

Monitoring and evaluation are closely related concepts, but they are not the same thing. **Monitoring** is an ongoing or periodic observation of program operations. The main purpose is to ensure that the program stays on course and that the operational procedures are revised if necessary. In the case of a drug court program, policymakers and program managers should monitor operations using indicators of program performance. These might include, for example,

- **Number of defendants screened** for program eligibility and for substance abuse problems and infectious diseases, and the results of those screening activities
- **Number of substance abuse treatment assessments conducted** and the results of those assessments
- **Number of persons admitted** to the program
- **Number of persons rejected** despite screening that indicated eligibility, and the reasons for the rejection
- **Characteristics of defendants** accepted or not accepted into the program, by
    - Demographics (age, sex, family status, race/ethnicity, employment status, and education)
    - Current charges
    - Criminal justice history
    - History of treatment
    - Medical needs (including detoxification)
    - Nature and severity of substance abuse problems
    - Results of drug tests.
- **Caseload status** of persons in the treatment program, including
    - Number of cases by length of time in treatment (0-30 days, 30-60 days, etc.)
    - Number of cases by completion of stages of the treatment process.
- **Number of persons who complete treatment** successfully
- **Number of persons terminated** from the program, including
    - Reason(s) for termination
    - Length of time in the program.
- **Accomplishments** of program participants in terms of
    - Sustained abstinence from alcohol and other drugs
    - Improved job skills
    - Improved literacy skills
    - Improved health
    - Improved life skills.

Having knowledge about these factors, and others selected as key indicators of performance, should enable program managers to accurately assess the program's effectiveness, and make good decisions about operational procedures and resource allocation. The data needed for program operations usually can be obtained from information used for day-to-day operations and routinely collected for each individual in the program. Although many programs rely on outside

evaluators to provide them with information on these topics, it should not be necessary to do so. With careful attention to the development of databases and computer software report formats (perhaps supplemented by manual counting in some instances), program managers can have such information monthly or weekly. Maintaining and sharing such information and using it to analyze program operations can make a significant difference in the effectiveness of a program.

The data needed for program operations usually can be contained from information used for day-to-day operations and routinely collected for each individual in the program. Evaluation, discussed in more detail in Chapter 6, also involves periodic observation of operations, but the focus is primarily on assessment of a program's effectiveness in achieving its original goals. Evaluation should draw on the same information base that enables policymakers and program managers to monitor operations. Feedback from evaluators, who are typically outside the day-to-day operations of a program, can be helpful in supplementing what the policymakers and managers know from monitoring program operations. However, if the policymakers and managers are doing a good job of monitoring, evaluation reports should seldom contain surprises.

Close attention to information needs, for individual case decision-making in both the justice system and the treatment community, for monitoring, and for evaluation, should be a part of the design stage for every program. It will be a critically important element of program operations.

Revising the Memorandum of Understanding (MOU)

When the design issues discussed in this chapter have been resolved, everyone involved in development of the program will know much more about key issues and operational details than they did when the policy development phase ended and design work began. It may be necessary to revise the Memorandum of Understanding to reflect any major changes.

The next stage in program development is project startup, followed by full-scale implementation, both discussed in Chapter 5. No matter how good the program design, the process of startup and full-scale implementation will almost certainly raise a number of unanticipated problems, requiring further revisions of the MOU at later stages.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Chapter 5 -- Implementation

Implementation of a program that integrates substance abuse treatment with pretrial case processing tests the soundness of all the preliminary decisions and requires the continued support of those who planned and designed it. No matter how careful the planning and how sound the program design on paper, actual implementation will require some adjustments. Implementing a drug court means change:

- **Changing operating procedures** in the court and other agencies involved in the program
- **Changing the philosophies** that underlie the day-to-day activities of the participating agencies, especially emphasizing the individual defendant's potential for rehabilitation through treatment
- **Establishing new working relationships**, especially those between substance abuse treatment personnel and criminal justice practitioners
- **Identifying new roles for both the justice system and treatment practitioners**, especially the judges, prosecutors, and defense lawyers handling cases involving substance-abusing offenders who are admitted to the program.

This chapter discusses eight major implementation issues:

- Personnel selection
- Facilities and transportation
- Education and training
- Startup operations
- Ongoing operations
- Case management
- Program organization and management
- Feedback mechanisms and program adjustments.

Personnel Selection

Perhaps the most critical decisions in program implementation are those concerning personnel. Often, many of the decisions about personnel will have been made before the implementation stage, and some key members of the program team will have been involved in the initial planning and program design phases. If so, they will be familiar with the program's goals and planned operating procedures and will have established working relationships with others

involved in the program. If not, or if only some members of the program team have been involved in planning and design, then selection of additional members of the team is extremely important for implementation.

Selection of personnel for the program team is complicated by the fact that team members are drawn from different institutions and agencies. Selection of team members is generally not done by a single "program director" but rather by the leaders of the institutions and agencies involved in the program. For example, the judge or judges are often designated by the chief judge of the court; the prosecutor or a senior deputy will select the assistant prosecutor(s) who will work with the team; and the public defender will select the assistant public defender.

It is highly desirable to begin program implementation with staff who, regardless of organizational affiliation, are convinced of the need for and effectiveness of substance abuse treatment for criminal justice populations. When key stakeholders such as the chief judge of the court, the prosecutor, and the public defender have been involved in the planning and design activities, the likelihood of having committed staff members assigned to the program is greatly enhanced.

As noted in Chapter 4, a typical interdisciplinary team includes a judge, prosecutor, defense attorney, screening officer, court clerk or coordinator, assessment officer, case manager, and treatment program liaison officer. It is important to recognize that, although many of the functions performed by these individuals will be new, the positions are not necessarily additions to the existing judicial and agency staff personnel rosters. Rather, because the new program involves cases that would be handled by the court in any event, judges and staff for the program can often be found by reorganizing workflow and revising personnel assignments.

Facilities and Transportation

Optimally, the court will have facilities for assessment and treatment in close proximity to the court. In Little Rock, Arkansas, for example, a substance abuse assessment unit, public health provider, treatment program, and court are all located in one building. In Washington, D.C., where urine screening is a major part of the drug court program, the D.C. Pretrial Services Agency has drug-testing facilities in the courthouse.

When assessment, drug testing, and treatment facilities are not located in or near the courthouse, it is helpful to develop transportation links between the court and the treatment providers. This is especially important during the early stages of a defendant's participation in the program when the defendant may not yet be totally committed to treatment.

In Miami, the court has a van that transports participating defendants directly from court to the treatment facility following the court proceeding at which the defendant was admitted to the program.

Education and Training

One of the clear lessons learned from attempts to introduce major innovations in American courts is that a significant amount of time and energy must be invested in education and training both before and during program implementation. The formal integration of substance abuse treatment and pretrial case processing on a large scale is a relatively new concept in the United States. Those working in a collaborative program involving the justice system and the treatment community must be educated about the underlying concepts and, in some instances, trained to perform new functions.

Education about a program involving the integration of substance abuse treatment and pretrial case processing should focus on

- The *purpose of* criminal case processing and substance abuse treatment
- The *concept of integration* of substance abuse treatment and pretrial case processing
- The *reasons why* the program is being undertaken
- The *goals and potential benefits* of the program
- The *types of cases that will be "targeted"* for admission to the program and the reasons for focusing on these case categories
- *How the program works* operationally and how this differs from current practices, with particular attention to
    - Immediacy of action, rapid screening of cases, and action focused on entry into the program shortly after arrest
    - Ongoing case supervision by the judge focused on the defendant's progress in treatment
    - Open and timely exchange of information concerning individual cases among the court, other justice system agencies, the treatment provider(s), and public health agencies
    - Policies toward defendant "relapses" that incorporate graduated sanctions and that rewards for progress in refraining from substance abuse.

Potential audiences for educational efforts focused on program implementation include

- Justice system, treatment community, and public health system administrators and supervisors
- Criminal justice practitioners who handle cases involving defendants potentially eligible for the program, including
    - Judges
    - Prosecutors
    - Defense lawyers
    - Courtroom clerks/program coordinators
    - Pretrial services and Treatment Alternatives to Street Crime (TASC) program staff members
    - Probation and community corrections department staff members
    - Law enforcement personnel.
- Substance abuse treatment staff members at all levels
- Bar and business leaders
- Legislative and executive branch officials at the municipal, county, and State levels
- Officials and senior staff members in agencies that can provide needed ancillary services (such as hospitals, other health care service providers, schools, and employment services)

- The media
- Community groups interested in criminal justice and substance abuse issues.

The approaches to educating members of these groups will vary from jurisdiction to jurisdiction, and by audience. To a significant extent, education about the program will take place during the planning and program design stages, as members of the planning group become familiar with basic concepts and with information on similar programs in other jurisdictions. Once the detailed program design has been developed and before full-scale implementation, concentrated efforts should be devoted to education directed at the audiences listed above and any others the planning team identifies as relevant to the program's operation. Job-focused training should be provided for the practitioners who will be involved in program operations so that they can learn how to perform specific functions such as screening, docket management, and cross-system liaison and coordination. Such training programs need not be lengthy but should be thorough. Often, a solid program overview, including a question-and-answer period, can be provided in less than 2 hours.

It is helpful to have a *resource book*, a loose-leaf compilation of materials about the program. Its contents could include

- A written description of the program, including a discussion of how it differs from traditional practices, the different "phases," and the potential benefits to participants and the community
- A statement of the program goals
- Copies of relevant legislation, regulations, or guidelines
- The program eligibility criteria
- A summary of program requirements (a list of the conditions a participant is expected to meet).

Also helpful for education and training is an *operations manual* describing the procedures to be used for screening, dissemination of information, informing the defendant about his or her options and legal rights, conducting assessments, supervising defendants' progress in treatment, imposing sanctions or rewards when appropriate, terminating defendants from the program when necessary, and acknowledging completion of the program by successful participants.

Finally, a *participant handbook* should be provided that answers questions the defendant may have about the program and contains

- A summary of the program evaluation plan
- A list of members of the project planning committee
- A list of the names, addresses and telephone and fax numbers of organizations and individuals that are involved in program operations or program oversight
- Copies of press reports about the program and about similar programs operating in other jurisdictions.

Some of the materials should be widely distributed to judges, lawyers, court staff members, treatment providers, and others involved in program operations. This can be done in the context of a special Implementation Workshops held prior to full-scale implementation.

Education and training for implementation should be treated as important ongoing processes, not one-time events, for at least two reasons. First, staff turnover in many courts, criminal justice

agencies, and substance abuse treatment agencies is high. In most jurisdictions, it will be only a short time before some positions crucial for program operations are filled by individuals who did not participate in pre-implementation education and training. The newcomers will need to know why the program has been adopted, and how the program works.

Second, it is likely that changes will be made in program scope and operations in light of experience gained in the implementation process and on the basis of information acquired through monitoring and evaluation. Everyone involved in or affected by the operation of the program needs to know about such changes, the reasons for them, and how they affect individual work responsibilities.

Startup Operations

Making the program work as intended often begins with a pilot program, during which operational problems can be identified and resolved before full-scale implementation is under way. Among the problems that jurisdictions with functioning drug courts have identified during the startup period are

- Inadequate funding
- Inadequate range of substance abuse treatment services
- Delays in identification or referral of potential program participants
- Need for support and assistance with specific client problems (such as housing, nutrition, medical, and legal services).

This introductory period gives program leaders and managers an opportunity to become familiar with each other's working styles and with a range of clients and their problems. It also enables managers to

- Develop operational procedures
- Locate and eliminate case processing bottlenecks
- Iron out communications problems
- Identify unanticipated management information needs
- Locate and arrange for needed services not initially planned for
- Refine plans for program evaluation.

Because defendants are accepted into a program gradually, there will be a period of time at the outset when the program is operating at less than full capacity. It is only after the program has been in operation for several months (or even as long as a year) and a "full" caseload has been developed that the dimensions of the docket management problems in the court will become apparent. Ultimately, the judge or judges handling this caseload will be performing two key functions: (1) **deciding on program admissions** for newly arrested defendants who are eligible to participate; and (2) **monitoring the treatment progress and compliance with program conditions** of defendants already admitted to the program.

As time passes and the number of active participants increases, supervision of the caseload will be increasingly time-consuming. The startup period provides an opportunity to develop

approaches to supervision of defendants in a range of cases and can be used to develop management strategies that will work effectively as the caseload increases.

For many of the key players, this will be a time in which they will encounter new concepts and new terminology, will begin developing working relationships, will start working with new procedures and forms, and will find themselves in unfamiliar professional roles. Almost inevitably, there will be some problems, confusion, and miscommunication during this period, and it will take time to develop smooth and efficient operations. Strong and committed leadership is especially important during this period, and program leaders may need to remind stakeholders (as well as members of the program team) that such problems are to be expected during the startup of any complex multi-organization collaborative effort.

Checking Up on the Program

As the program begins to move from the startup period to full implementation, it will be important to review the initial plans and program design. It is likely that new information acquired during the startup period will point to the need for some changes in program design. If so, key stakeholders and policymakers (as well as members of the program team) should be informed about what has been learned and should be involved in decisions regarding plans for full implementation.

Optimally, this sort of review will be done periodically after full implementation is under way. It is essentially a revisiting of initial policy decisions on the key areas of ongoing operations, case management, and program management based on new information acquired through close monitoring. The following is a checklist of topical areas to be reviewed, with some illustrative questions.

Ongoing Operations

Program Goals

- Are the original program goals still sound in light of initial experience with operations?
- If not, how should the goals be modified?
- Are program managers regularly receiving management information that enables them to assess program performance in relation to goals?
- Is the program evaluator confident that information will be available to assess program performance in relation to goals?

Target Group

- How accurate were the original projections concerning the size and composition of the population of defendants targeted for participation?
- Are targeted participants being screened?
- Are they opting to participate in the program?
- Are the anticipated caseload levels being reached? Exceeded?

- If there is either an over- or under-enrollment of the target population? What adjustments should be made?

Screening

- How well is the screening process working?
- Is screening being done in all three key areas, substance abuse problems, health and mental health issues, and criminal justice history and current charge? If not, what are the obstacles? How can the obstacles be overcome?
- Is the screening process resulting in identification of all defendants eligible for participation in the program? How rapidly is this being done?
- If screening is taking more than 24 hours from arrest, what are the obstacles to expeditious screening, and how can these obstacles be overcome?
- Are screeners identifying detoxification needs of candidates?

Detoxification Services

- What detoxification services are being provided?
- What agency provides these services?
- When are they provided, in relation to
    - Initial arrest?
    - Assessment?
    - Decisions of the defendant and the court concerning admission to the program?
- What methods are used?
- How do these methods vary by the type of drug and the severity of the defendants' substance abuse problems?
- What is the duration of these services, and how does this vary by the nature and severity of the substance abuse problem?
- What is the cost (overall and per defendant) of these services?
- Are there other approaches to detoxification that should be considered? If so, why? What are the programmatic and cost implications of possible alternative approaches?

Assessment for Substance Abuse Treatment

- Who (what agency or agencies and what individuals) performs assessments of candidates for the program?
- What is covered in the assessments?
- When is the assessment conducted in relation to
    - Initial arrest?
    - Commencement of detoxification services?
    - Decisions by the defendant and the court concerning admission to the program?
- How useful is the information in the assessment for purposes of decisions concerning
    - Admission to the program?
    - Matching of the defendant with a particular provider or set of treatment modalities?
    - Actual treatment?

- If completion of the assessment does not take place immediately following referral for assessment, are there any ways in which a partial assessment can be done rapidly to provide information needed for initial decision-making by the court concerning admission?
- What assessment instruments are used?
- How effective are these instruments in producing information useful for decision-making and case management?

Program Admission Criteria

- In light of initial operating experience, are the program's admissions criteria still appropriate?
- What modifications, if any, may be appropriate in order to reach more (or fewer) members of the target group?
- Are there specific reasons why eligibility and/or admissions criteria should be either tightened or relaxed?
- Are the screening and assessment processes providing the information needed to make sound and expeditious decisions concerning program admissions? If not, what changes need to be made in operating procedures?
- What range of graduated sanctions will be available?

Case Management Checklist

Treatment Services

- What substance abuse treatment services are being provided and by whom?
- If there is a single treatment provider, what is the range of services?
- If there are multiple providers, in what ways are their programs different? What gaps exist in the types of treatment services currently available for defendants in the target group?
- How can the gaps be filled?
- What appear to be the initial results of treatment, as indicated by key performance measures (such as urine screens, attendance at counseling sessions, rearrest data, and program reports on participant progress)?
- To what extent, and in what ways, do different approaches to treatment appear to be producing better results?

Linkages With Ancillary Services

- What ancillary services are directly linked with the program and available to participating defendants?
- What gaps, if any, need to be filled in order to adequately complement the direct substance abuse treatment services? Consider especially
    - Education, including basic literacy and math skills
    - Nutrition
    - Housing
    - Child care
    - Medical treatment
    - Job training and counseling.

Policies and Practices Concerning Relapse

- How are the judge and other members of the "courtroom team" informed of defendant's progress (or lack of progress) in treatment?
- What actions are taken by the court if reports indicate continued substance abuse and lack of progress in treatment?
- Have clear policies been developed to impose graduated sanctions (consequences) for noncompliance?
- What sanctions are used? Under what circumstances?
- How well do these sanctions work?
- Are there other sanctions that should be considered for use in some circumstances?
- What incentives are available when reports indicate progress in treatment?

Policies Concerning Termination of Program Participation

- Under what circumstances will a defendant's participation in the program be terminated? How are decisions concerning termination made? What are the roles of the judge, other justice system practitioners, and the treatment provider?
- What is the practical effect of termination on the status of pending criminal charges?
- How many defendants have been terminated from participation in the program before completion and for what reasons?
- Are current policies concerning termination sound? If not, what changes should be made?

Program Duration, Completion, and Graduation

- What is the duration of the program?
- To what extent and under what circumstances may the time required for completion of the program vary by defendant?
- Are there minimum time requirements or criteria for program completion?
- When and how are these requirements communicated to the defendants?
- What are the practical consequences of successful completion of the treatment program, in terms of the underlying criminal charges?
    - Are charges dismissed?
    - If there has been a guilty plea, can the plea be vacated?
    - Are records sealed?
- What "graduation" ceremonies or other acknowledgments of successful completion of the program take place? What is done on these occasions?
- Are there any changes that should be made with respect to program completion and graduation?

Aftercare

- What aftercare services are provided for defendants who satisfactorily complete the treatment program?
- Who is responsible for provision of these services?
- How are aftercare services linked to pre-graduation treatment services?
- How are aftercare services paid for?

- What roles (if any) do the court and other criminal justice personnel have in the provision of aftercare services?
- How difficult is it for the defendant to obtain access to these services?
- Are they provided on a proactive "outreach" basis, or must the defendant seek them out?
- What are the criteria for continued provision of (or termination from) aftercare services to specific clients?

Program Organization and Management Checklist

- How is the program organized for actual operations? Who is responsible for what?
- How (if at all) does the actual operational organization differ from what was contemplated during the planning and program design stages?
- How well is the cross-system collaboration working in practice?
    - What are the strengths?
    - What are the weaknesses?
    - Are there frictions or personality conflicts that need to be addressed?
- What changes in organizational structure are desirable (or necessary) in order for the program to achieve its goals?
- What staffing or consultant needs can be identified? Are there places in which the program is overstaffed or where existing staff are not doing the job well?
- Are there ways in which program scope and staffing should be expanded? Contracted?
- What is the role of the original stakeholder/policy-maker group?
- What is the relationship between the operating program (and its leaders) and the broad stakeholder group?
- How does the stakeholder group regard program operations to date?
- What needs to be done to ensure an effective ongoing relationship between program personnel and the stakeholder group?

Management Information

- Is accurate information needed for decision-making in *individual cases* available, on a timely basis, to
    - Judges and court staff?
    - Prosecutors?
    - Defense attorneys?
    - Case managers?
    - Treatment providers?
- What essential information is not readily available?
- What must be done in order to ensure that the information is available?
- Are management information reports necessary for assessment of overall program performance regularly produced?
- Are they disseminated to all of the relevant program team members?
- Do the reports provide information that is accurate and useful for assessing the program's performance in relation to its goals?
- Are they useful for identifying potential problem areas?
- What is not covered by these reports that might be of interest to
    - Program leaders and managers?

- An evaluator?
- Key stakeholders including present or potential funding sources?

Evaluation

- Has an evaluator been selected?
- Is the evaluator fully familiar with the background of the program and with its goals, organizational structure, and operational procedures?
- Has the evaluation design been reviewed by program managers and other key players?
- Does the design address the questions that the program managers and key stakeholders would like to have answered about program operations and impact?
- Is the information needed for evaluation readily available?
- Has the evaluator made any assessment of program operations and impact during the startup period?
- If so, what are the findings?
- Are they consistent with the information available to program managers?
- What are the implications of these findings for full-scale implementation?

Legal Issues

- Have the pertinent legal issues (seeChapter 8) been addressed in program design and in actual operations?
- Are defendants' constitutional and other legal rights adequately protected under the program's operating procedures?
- Have arrangements been made to ensure the necessary exchange of information between the justice agencies and the treatment providers while still complying with laws regarding privacy and confidentiality?
- Does the program have the insurance coverage necessary to protect against possible liability?

Costs and Budget

- Have all of the costs of program operation been identified?
- Is there a budget for program implementation that identifies both the costs and the funding sources for all components of program operations for the current and next fiscal year?
- If there are funding gaps, what are the options for filling the gaps or making other adjustments?
- To the extent that the program is supported by grant funding, what plans exist for obtaining more permanent funding at the expiration of the grant period?

Program and Budget Review

- What mechanisms and procedures have been established for oversight and review of program operations by the original group of stakeholders or a successor group?
- Who should be involved in such a group?
- What should be the role and functions of the oversight or review group?
- How should it relate to the program team?
- What information should it receive?
- How can the oversight or review group best support and reinforce the program team?

Operations Manual

- Does the program have an operations manual describing its current organizational structure, staffing, and operational procedures?
- If not, what should it include?
- Who should be responsible for preparing the manual and keeping it updated?

(Note that many of the topics covered in these checklists are appropriate for inclusion in such a manual.)

Information for Participants and the Public

- Does the program have a participants' handbook describing how the program works, rules or conditions governing participation in the program, services provided, treatment procedures and phases, and other aspects of the program?
- If so, does the manual cover everything potential program participants should know and understand?
- Is it written in a language that program participants will be able to read and understand?
- Are there videos or other materials that can help explain program goals and policies to participants and others who may be interested in program operations?
- Have press kits or other such informational packets been prepared to distribute to media representatives, funding officials, or visitors from other jurisdictions who might be interested in how the program works?
- If these materials have not been prepared, who will be responsible for preparing them and keeping them updated?

Feedback Mechanisms and Program Adjustments

The checklists in the previous three sections can provide a useful tool for periodically reviewing program operations. Given the environment in which these programs exist, one in which laws and policies regarding substance abuse treatment and health care are rapidly changing and in which financial support for public institutions and programs is always under scrutiny, it is critical for program leaders and managers to seek and use information about program effectiveness. Evaluations are one source of such information, but evaluation reports are not always produced in time to help guide programs through mid-course adjustments and funding crises. Effective leaders and managers will constantly be asking practitioners, program participants, and policymakers for information and ideas about program performance, as well as reviewing management information reports to assess progress and identify problems. They develop both formal and informal feedback mechanisms and use the information, in consultation with staff, knowledgeable consultants, and policy oversight groups, to reshape program operations when necessary and to plan for the future.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
Treatment Improvement Protocol (TIP) Series 23

Chapter 6 -- Program Evaluation

Program evaluation should be a process, not a one-time event, that begins before the startup of a program. The evaluator should be selected and the evaluation design developed while the program is in the design stage; that allows the evaluator and the program planners to jointly address key evaluation issues, for example, the articulation of program goals and the identification of appropriate performance measures, before implementation begins. The collaborative process, with ongoing communication and exchange of information, should then continue through the life of the program.

In the real world, arrangements for evaluation often fall short of the ideal. All too often, evaluators come into the picture only when implementation is about to begin or, worse, after it is well under way. The earlier evaluators are brought into the planning and program design process, the better.

This chapter is not a detailed guide to evaluation strategies and methods. Rather, it is an overview of ways to evaluate programs that integrate substance abuse treatment with the pretrial processing of criminal cases. The following topics are covered in a broad-brush fashion:

- Process evaluations
- Outcome evaluations
- Cost-benefit analyses
- Selection of an evaluator
- Funding for an evaluation.

Process Evaluations

Process evaluations answer questions about how well a program is meeting administrative and procedural goals and should generate valuable information about program structure and operations. Questions typically addressed in a thorough process evaluation include the following:

How well is the program achieving its goals in terms of provision of services?

- To what extent is it reaching the intended target population? If the target group is not being reached, why not?

- What services (such as detoxification, assessment, treatment, and aftercare services) are being provided? To which program participants?
- What services not currently provided should be added? What current services should be dropped or modified? Why?
- What problems have been encountered in program implementation? To what extent, and how, have the problems been overcome?

Ideally, program evaluation will begin before program startup, with an evaluator selected and an evaluation design developed while the program is in the design stage.

What are the characteristics of the defendants participating in the program?

- To what extent, and in what ways, do the characteristics of participants differ from what was anticipated during the program design stage?
- What are the principal treatment and ancillary service needs of participants?
- Do program services reflect the needs of participants?
- Does the program provide culturally appropriate services and staff to address the needs of participants?
- Does the program provide treatment services and settings that can adequately address the needs of the full range of participants?

How does the program affect the work of courts, and other justice system agencies, and the overall delivery of substance abuse treatment?

- How do program operations affect caseloads and resource allocation in the court?
- How do program operations affect the delivery of treatment services to clients not involved in criminal cases?
- What are the attitudes and perceptions of justice system leaders and key practitioners?
- What are the attitudes and perceptions of treatment providers and public health officials?
- What are the attitudes of community leaders?
- How do key stakeholders in the jurisdiction perceive the effectiveness and value of the program?

Process evaluations will typically use information from a wide range of sources. The purposes are principally to describe and analyze actual operations in comparison to initial plans and to identify key implementation issues for review by program managers and key stakeholders. The primary audience for a process evaluation should be the program managers and key stakeholders in the jurisdiction, but good process evaluations should also be of interest to policymakers and practitioners in other jurisdictions that are considering program replication or adaptation. They can also be valuable in describing the context or environment in which program outcomes take place, and in that sense are closely related to outcome evaluations.

Outcome Evaluations

Outcome evaluations focus on the goals of the program, both in terms of its impact on individuals and its impact on collaborating systems and the larger community. For example, if the program adapted goals similar to those outlined in Chapter 2, the evaluation design would attempt to measure success (or at least progress) in relation to those goals.

Experimental Designs

Experimental designs are the preferred method for outcome evaluations. Using an experimental design, defendants would be assigned to one of two groups: (1) an experimental group that participates in the full range of program activities and is eligible for all services; or (2) a control group that does not receive program services or receives only the services that were available before implementation of the program. The principal advantage of experimental designs is that a relatively high degree of confidence can be placed in findings of differences in outcomes between the two groups.

It is not always feasible, however, to use an experimental design. First, experimental designs that minimize possible "contamination" of the experiment can be expensive. Second, they may not be ethical or legal. For example, a judge, prosecutor, or defense attorney may object to random assignment of defendants to services, arguing that it is unfair or a denial of equal protection of law to arbitrarily withhold beneficial program services from eligible defendants who have a demonstrated need for treatment.

One strategy that has been used to allay concerns related to defendants' need for, or rights to, treatment is to assign defendants to one of several different "categories" of treatment. For example, defendants might be randomly assigned to a more intensive group (daily outpatient groups, drug education, and drug testing), or to a less intensive group (only drug education and drug testing). This strategy ensures that all defendants identified as needing substance abuse treatment receive some services. Experimental designs are generally more tenable when defendants are not ordered by the court to participate in the program and when defendants provide a full and informed consent regarding their involvement in randomization procedures and other program evaluation activities. Evaluation procedures, including legal and ethical issues, should be carefully reviewed by judges, prosecutors, and defense attorneys before an experimental evaluation design is implemented.

Quasi-Experimental Designs

If an experimental design is inappropriate, for whatever reason, a second approach is to develop a quasi-experimental design that allows for scientifically rigorous examination of outcomes. One type of quasi-experimental evaluation is a pre-post design, in which outcomes obtained following discharge from a drug court program are compared to those obtained prior to program participation. For example, defendants' frequency of drug use, frequency of arrests, or length of time between arrests can be compared before and after admission to the program. A drawback to pre-post designs is that they do not take into account other factors that may contribute to the behavior changes they measure. For example, a reduction in drug use among program

participants might be influenced by a sudden decrease in the supply of drugs in a community. Using a pre-post design, this reduction might mistakenly be attributed to involvement in treatment. In contrast, an experimental design would demonstrate reductions in drug use among both the "treatment" and "no-treatment" groups, making it clear what effects on drug use were attributable to the program.

Another type of quasi-experimental evaluation studies one or more comparison groups, rather than a randomly assigned control group. Using this design, results from the experimental and comparison groups are contrasted. Comparison groups consist of substance-abusing defendants who do not participate in (or who do not complete) the drug court program. These groups should include defendants who have substance abuse problems and who are otherwise similar to program participants in key areas such as criminal history, severity of most recent offense, age, gender, ethnicity, substance abuse history, employment, income, and other areas used as eligibility criteria in the program. It is often useful to "match" subjects in experimental and comparison groups to control for the problem of confounding variables introduced through nonrandom assignment. Using this approach, both groups' subjects are selected based on factors expected to affect outcomes, such as age or educational attainment.

One useful type of comparison group consists of defendants placed on a program "waiting list." Use of such a group minimizes differences in motivation for treatment and other potential differences in program eligibility that may affect evaluation outcomes. Other comparison groups could include: (1) defendants who are eligible for the program but elect not to participate; (2) defendants who are discharged from the program prior to completion; and (3) other groups of defendants who are similar to program participants in the areas described above.

Process evaluations answer questions about how well a program is meeting administrative and procedural goals. Outcome evaluations focus on the goals of the program, both in terms of its impact on individuals and its impact on collaborating systems and the larger community.

Cost-Benefit Analysis

In an era of fiscal restraint and close scrutiny of social services programs, program leaders should expect evaluators to study the costs and benefits of a program integrating substance abuse treatment with pretrial case processing. Cost-benefit analysis builds upon both process and outcome evaluations. The cost side of the study requires a good understanding of the program's operating procedures and of the actual costs of those operations for all the participating organizations. The benefits are the positive outcomes sought by the program.

Cost-benefit evaluation strategies focus on the economic impacts of substance abuse treatment before and after involvement in the program. Cost-benefit analysis must build on a solid foundation of knowledge about program operations, impact, and costs of the program as well as criminal justice, health care, and labor market operations and costs. Such analysis requires time

(for follow-up on participants' post-program behavior), specialized expertise in justice system and health care operations and economics, and money to support the research. See Chapter 7 for an example of a cost-benefit analysis.

Selecting an Evaluator

Evaluations are usually conducted by an outside or "independent" evaluator -- an individual or group that has no affiliation with the organizations involved in the program, and is thus less likely to have a conflict of interest or bias about the merits of the program. However, it is possible to have objective "internal" evaluations, and in some jurisdictions there are criminal justice agencies that have highly competent in-house research departments capable of evaluating the program.

Regardless of whether evaluators are external or internal, they must have experience conducting evaluations. Ideally, the evaluator will be knowledgeable about both justice system operations and substance abuse treatment. If a potential evaluator has experience with criminal justice operations but not with substance abuse treatment, or vice versa, the evaluator should be involved early, while the program is still in the planning and design stages, if possible.

The evaluator should be someone in whom the program team has confidence, because trust and open communications are important elements of a good evaluation. The evaluator should be willing to develop strategies that address questions important to program managers and key stakeholders and to regularly update program staff on preliminary findings from the evaluation. The evaluator will need full access to program records and to management information reports and other documents relevant to program operations and will need to be able to interview program staff, clients, and policymakers. There should be full agreement between the evaluator and the program leaders from the outset, preferably, before initial implementation of the program, on the goals and objectives of the program and of the evaluation, on the performance measures and evaluation methods to be used, and on the procedures, costs, timelines, and report review procedures to be followed. The agreement can be formalized in a contract.

Regardless of whether evaluators are external or internal, it is critically important for them to have experience conducting evaluations. Ideally, they will be knowledgeable about both justice system operations and substance abuse treatment.

Funding for an Evaluation

The scope, focus, and depth of an evaluation will necessarily be limited by the funds available. Using a very rough rule of thumb, evaluation is sometimes budgeted at 5-15 percent of the overall program budget, but the percentage actually spent varies considerably depending on the circumstances (and the degree of interest the policymakers and program managers have in evaluation of the program). Regardless of the amount of funds available, close attention should

be paid to evaluation priorities and strategies. The following are some key questions to be asked, by both the evaluator and the program leaders, in developing evaluation priorities and strategies:

What are the most important things to know about the program in terms of operations and/or impact?

- What data are needed to answer these questions?
- What relevant information is already available?
- Given available resources, what additional data can be collected and, together with data already available, analyzed to produce answers to the top priority questions?
- How will preliminary findings be presented and reviewed, with opportunity for input from the program team and key stakeholders, before submission of a formal report?
- How can the evaluation findings be used? How can a focus on these questions, using these research techniques, help shape program policy and practice?

A range of local, State, Federal and private resources may be available to help support evaluations of drug court programs. If funding is limited, assistance from colleges and universities may be sought. Often, they have social science departments looking for places to conduct evaluation and research.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Chapter 7 -- Program Costs and Financing

Programs to integrate substance abuse treatment with pretrial case processing cost money to run. Funding must be found to pay for the costs of treatment, ancillary services, and all the other treatment, justice system, and public health functions. This chapter focuses on identification of program costs and strategies for meeting those costs.

Identifying Program Costs

The costs of a program can be broken down into its component parts. Since programs will vary widely depending on the size and composition of the target group, the point(s) in the court process at which program intervention occurs, the types of treatment services provided, and a myriad of other factors, the costs will vary widely from jurisdiction to jurisdiction. The following is a preliminary list of possible costs:

Treatment and ancillary services costs. These are the costs of all of the treatment and treatment-related services provided by the program. Depending on the scope of the program and size of the target population, they could include any or all of the following:

- Substance abuse screening
- Detoxification facility and services
- Substance abuse assessment and treatment planning services
- Counseling therapy (group, individual, family)
- Medical assessment and treatment services
- Mental health services
- Drug testing equipment and lab services
- Child care
- Case management and court liaison services
- Computers and software
- Job training and counseling
- Special costs associated with inpatient or residential treatment, if used
- Social service support such as assistance in obtaining housing, food and medical care
- Aftercare services

Justice system costs. When a program integrating substance abuse treatment with pretrial case processing is implemented in a jurisdiction, the courts and most or all other justice system agencies will be performing new functions. Reorganizing operating procedures will involve costs, especially if new equipment must be purchased or new staff must be hired. The following is a list of the types of costs that can potentially be incurred:

- Salaries and fringe benefits for justice system personnel working on the program
    - Court personnel (judges and staff)
    - Prosecutor's office staff
    - Defense services
    - Pretrial services
    - Probation services
    - Jail personnel services.
- Computers, software, and programming services
- Drug testing equipment and lab services
- Costs of facilities and services used to impose consequences for noncompliance with program conditions

Other costs. Some costs cannot be easily allocated to either treatment or the justice system. They include:

- Costs of transportation of clients
    - From court to detoxification or treatment facility
    - From client's home to court or treatment.
- Program evaluation
- Costs of consultants to assist in program design, education, training, and ongoing monitoring and review of operations.

Using Cost-Benefit Analysis

Cost-benefit analyses can not only justify a program to outside funding sources; they can help leaders decide how to reallocate funding internally too. A study recently published by the California Department of Alcohol and Drug Programs (CALDATA) illustrates ways that costs can be broken down. The study analyzed benefits in relation to costs in three broad areas: (1) the effects of treatment of participant behavior, (2) the cost of treatment, and (3) the economic value of treatment to society.

Some of the variables in the criminal justice system that can -- and should -- be measured using the CALDATA methodology to determine cost benefits of treatment are

- Reductions in costs associated with defendants involvement in the criminal justice system
    - Costs per arrest
    - Costs of crime-related court case processing and legal services
    - Costs of incarceration in prison and jail
    - Costs of probation and parole services
    - Costs related to victim losses, including thefts.
- Reduction in costs of the health care system

    - Costs of outpatient and inpatient medical care related to substance abuse
    - Costs of emergency care
    - Costs of inpatient and outpatient mental health care
    - The costs of those who have communicable disease that is untreated (e.g., TB, HIV, other STDs).
- Increased economic productivity of program participants
    - Increased earnings
    - Reduction in costs related to welfare and other social services.

The 2-year CALDATA study examined outcomes for a sample of nearly 150,000 persons who received substance abuse treatment in California in 1992, and found that the cost of treatment was $209 million. The benefits, in terms of cost savings during treatment and the first year after were approximately $1.5 billion. Thus, for every dollar spent on treatment, about $7 was saved, mainly in reduction of criminal activity and in the hospitalizations for health problems.

At the local level, program managers can follow the CALDATA study approach in estimating program benefits in relation to costs. Equally important, they can use the evaluations to garner outside funding.

Funding Strategies

Once the costs of program components have been identified, it is time to develop funding strategies. It is important to remember at this point that not all costs of a program are necessarily new costs. The functions being performed by the program are to some extent displacing functions previously performed, and many if not all of the justice system costs can be met by reorganizing staff and procedures. The principal costs for a treatment drug court program are likely to be the costs of treatment services. There are a variety of ways in which these costs can be met including

- Insurance reimbursement through the defendant's own health insurance or through Medicaid or other publicly funded insurance
- State or local funding of substance abuse treatment services
- Grant support for treatment services, from foundations or public agencies
- Fees paid by defendants participating in the program.

Most of the treatment drug courts created since 1988 were started *without* significant infusion of outside resources and often without any outside resources whatsoever. They were developed through local initiatives, using local resources. More federal funds have become available in the last year from the U.S. Department of Justice's Office of Justice Programs. The major support for the treatment infrastructure remains the U.S. Department of Health and Human Services' Center for Substance Abuse Treatment.

Particularly in view of the uncertainty of federal grant support, it is important for planners to involve potential state and local funding sources from the outset. In this connection, the office of the State Alcohol and Drug Abuse Director has a particularly important role. This agency has significant responsibility for the allocation of Federal and State funds available for substance

abuse treatment and can be an invaluable source of assistance in program design as well as direct funding.

Even if Federal or foundation funding is available to help get a program off the ground, long-term funding support will have to come principally from State and local sources. If representatives of these sources are involved from the outset, they can be educated about the goals and values of the program, and they can also advise program leaders about what indicators of success will win the program long-term funding support.

Approaches to Short-term Funding Needs

Although the long-term viability of treatment drug court programs will depend mainly on their capacity to persuade State and local funding sources of their worth, there are a variety of short-term approaches to funding that warrant attention from program planners. These include the following:

Volunteers. Programs integrating substance abuse treatment with pretrial case processing require a great deal of labor. The provision of ancillary services, in particular, is an area in which volunteers can play an especially valuable role. Community service organizations, professional organizations, and interested individuals are potential sources of volunteer assistance. Volunteers will need training (and training costs must be built into the budget), but they can be immensely valuable assets to a program.

Grants. A valuable asset to a program is a person with experience in preparing grant applications, either as an employee or as a consultant. These individuals can help identify potential funding sources and prepare persuasive proposals to government and private funding sources.

Local philanthropists. Philanthropists in the community are often willing to contribute to creative programs that cannot be funded by government grants or other conventional funding sources. The Foundation Center in Washington, D.C. publishes a directory of philanthropic organizations and the types of programs they fund. Health and human service-related projects are funded by a number of foundations, including the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, and the Pew Charitable Trust.

Nontraditional partners. Treatment drug court programs provide opportunities for new partnerships involving the justice system, the treatment community, and a wide range of organizations that ordinarily have little or nothing to do with courts or substance abuse treatment. For example, chambers of commerce and other civic organizations may be able to provide job placement services or apprenticeship programs. Grocery stores and restaurant chains can provide jobs. Churches can provide meeting space for support groups as well as emotional sustenance.

Entitlement and insurance income. It is important for program leaders to know what entitlements and insurance income their clients are eligible for. Some defendants are eligible for entitlement programs that can help fund substance abuse treatment and ancillary services. For example, clients with children may be eligible for funds and services from State programs in the

areas of child care, nutrition, housing, and employment. Younger clients may be entitled to educational support. Many clients will probably be eligible for employment funds in the community. Veterans of the armed services are probably eligible for a wide array of Department of Veterans Affairs programs. The local public health agency will be likely to have a number of programs for which clients are eligible, including ones on prenatal care, family planning, nutrition counseling, TB testing, STD prevention, and HIV/AIDS education.

There are a number of "third party payment systems" that can potentially be used to help fund substance abuse treatment, depending on the circumstances of the individual defendant/client. They include:

- Medicare
- Supplemental Security Income (SSI) disability assistance
- CHAMPUS (the Federal system of health care payments for military personnel and their dependents)
- Private health insurance
- Medicaid.

The Impact of Managed Care

In recent years, health care reform has been a major focus of attention for the States. While there is no way to accurately predict how laws governing funding for health care (including substance abuse treatment) will change, it is certain that managed care will continue to place stringent time limits on health care services. As drug courts develop, regardless of their initial sources of funding, judges will need to be aware of new legislation and regulations affecting funding for substance abuse treatment services and initiate discussion on alternative policies that support drug court objectives.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Chapter 8 -- Legal and Ethical Issues [1]

Integration of substance abuse treatment and pretrial case processing raises a broad array of legal and ethical issues. In this chapter, four key sets of legal or mixed legal and ethical issues are discussed, including:

- Issues of constitutional law, including questions related to the constitutionality of program operations under the equal protection clause of the U.S. Constitution
- Legal issues arising under Federal and State laws concerning the confidentiality of information acquired during the course of treatment
- Ethical concerns related to the voluntariness of the defendant's participation in treatment.

Equal Protection

The Fourteenth Amendment to the U.S. Constitution prohibits States from "deny[ing] to any person within [their] jurisdiction the equal protection of the laws." "Equal protection" does not mean that everyone must be treated in the same way. It means that if distinctions are to be made in the way the State treats people, then those distinctions must have a "rational relationship" to the State's objectives or be supported by a "compelling State interest." Distinctions may not be made on the basis of arbitrary classifications.

Any alternative processing program that systematically excludes a particular class of people -- such as African Americans or women -- would clearly be in violation of the equal protection clause. Does this mean that programs that exclude defendants who are accused of violent offenses, as most do, are unconstitutional? And what about programs that exclude everyone over a certain age?

Most programs that exclude defendants who have committed violent crimes do so on a number of "rational bases." The State has an interest in focusing its limited resources on rehabilitating defendants who are most likely to benefit. Violent defendants often have different or more serious problems than nonviolent defendants. In addition, the State has an important interest in protecting the public safety.

Programs that accept only youthful defendants are supported by similar arguments. The State can act on the hypothesis that youthful defendants are more likely to benefit from treatment;

treatment of youthful defendants theoretically also is more cost-effective because if they continue to abuse drugs, it is likely that they have longer criminal careers ahead of them.

If programs that exclude certain classes of defendants on a reasonable basis are constitutional, what about programs that treat "similarly situated" defendants, those in the same "class," differently. Two defendants who have committed exactly the same crime may be treated quite differently: a program may offer one defendant charged with drug possession the option of entering treatment in lieu of criminal justice processing while denying that option to another defendant charged with the same offense. By the same token, a defendant who is accused of committing a relatively minor crime may be subjected to court supervision as long as a defendant who is accused of committing a serious crime.

Is this "unequal" treatment unconstitutional? Probably not. The Constitution permits the State to make distinctions between individuals (as well as "classes" of individuals) if those distinctions are based on reasonable criteria. Thus, treating differently defendants who have been accused of committing the same type of crime is acceptable if the distinction is made because of differences in the addiction or criminal histories of the two defendants or differences in other mitigating or aggravating factors in their backgrounds. Treating identically defendants who are accused of committing dissimilar crimes is acceptable if the defendant accused of the lesser crime has a more extensive criminal history, or if the two defendants need the same kind of treatment, or if there are other factors that warrant similar treatment.

Thus, defendants are usually sentenced on an individual basis, and their backgrounds and needs are factored into the ultimate decision. Rarely does the system require the court to treat all defendants convicted of similar crimes in exactly the same way. Indeed, the argument against mandatory sentencing, which requires the judge to impose a particular sentence for an offense, is that it is unfair precisely because it does not permit consideration of defendants' backgrounds or of mitigating and aggravating circumstances.

Even defendants who receive identical sentences, probation or incarceration for identical periods of time, may be treated differently. The justice system sometimes rewards defendants on probation for good behavior by discharging them early from supervision. Prison inmates may lose "good time" by violating prison rules, which causes them to be incarcerated for longer periods of time than those who drew the same sentences for the same crimes, but behaved the way prison authorities wanted them to. Few would argue that the justice system should abandon these kinds of distinctions.

Thus, at every stage of the criminal justice system, we treat similarly charged, similarly convicted, and similarly sentenced defendants differently, based on their backgrounds and their actions after their arrests.

One approach to dealing with equal protection concerns would be to "equalize" the length of time in treatment for all defendants who are accused of committing the same crime, but whose addictions vary in severity. One suggestion would require the same length of time in treatment, but vary the intensity of services. This idea presents difficulties, however, because it requires defendants to stay in treatment after they have complied fully, gained what they can, and should

have graduated. This raises a number of ethical and practical issues: For defendants who should have graduated, it means they are no longer matched to an appropriate treatment program, but instead are being punished rather than treated. For the treatment program, it means having a valuable treatment slot occupied by someone who no longer needs it. Finally, this solution does not preclude the theoretical possibility of a constitutional challenge. The defendants who receive more intensive services might object that they do not receive precisely the same treatment as those who entered the less intensive program.

A second suggestion for equalizing time in treatment for all defendants who have committed similar crimes would add components like community service or educational requirements for those defendants who require less time in treatment. This solution is interesting because it does not require defendants to remain in treatment when they no longer need it. However, problems with this model exist as well. First, many jurisdictions already require some defendants convicted of certain kinds of minor crimes to perform community service. Second, adding additional requirements to equalize the time all defendants must participate in a program despite their different needs for treatment extends the State's control over a group of individuals who would otherwise have completed their obligations to the system. Third, defendants who receive longer treatment may object that they are denied the benefits of any ancillary educational services that the other group received when its treatment ended.

The wiser course seems to be to acknowledge the reality that defendants committing similar crimes may be treated differently in a drug court program. If, before they enter the program, full disclosure is made to defendants that substance abuse treatment will be tailored to their needs (including whatever that may mean in terms of intensity and length), it is unlikely that a successful lawsuit could be brought on equal protection grounds.

A court's response to an equal protection challenge by a defendant who has agreed in open court to participate in alternative processing and who has acknowledged that no promises have been made regarding the length or intensity of treatment might well be: "The court allowed you to participate for your own benefit. If you are not satisfied, you can always opt to leave treatment and go back into criminal justice processing."

Due Process

The Due Process Clauses of the Fifth and Fourteenth Amendments prohibit the government from "depriv[ing] any person of life, liberty or property, without due process of law." Due process of law basically means that government must provide individuals with some kind of notice and an opportunity to be heard before it can deprive them of any right or privilege.

Does this mean that if a treatment drug court program seeks to terminate the participation of a defendant because of noncompliance, there must be a "due process" hearing? No, it doesn't.

The Supreme Court has held that the Due Process Clause requires a hearing before an offender's probation or parole can be revoked (*Morrissey v. Brewer*, 408 US 471 [1972] [parole*]; Gagnon v. Scarpelli*, 411 US 778 ([1973] [probation]). However, similar requirements are not ordinarily applicable to defendants in drug courts while their cases are pending. The drug court follows a

diversion or deferred prosecution model. Procedural rights have usually been waived allowing for summary decisions by judges.

The practice in individual drug courts vary. In the Miami drug court model, it is the judge who makes the final decision about termination, in open court, after a hearing at which the defendant is represented by counsel. In the Brooklyn, New York, Drug Treatment Alternative-to-Prison (DTAP) model, the treatment program provides a due process hearing, in accordance with New York State regulations. Why this difference? In Miami, the court is an integral part of the treatment process. The defendant is diverted directly from the courtroom and reports back to the judge periodically. The judge has access to the defendant's treatment records. DTAP does not involve the court in the treatment process. Once defendants enter treatment, the court hears no more about them unless their treatment is terminated and they return for criminal justice processing, or they graduate and their criminal cases are terminated.

Federal and State Confidentiality Laws

For integration of substance abuse treatment and pretrial case processing to be effective, information must flow between the treatment program and the criminal justice system. Most treatment drug court programs rely on detailed information flowing regularly to the judge, prosecutor, and defense attorney. This information (including the defendant's attendance record and drug test results) enables the drug court judge to "work with" the defendant, offering praise for good performance or criticism (or punishment) for failure. Programs designed to integrate substance abuse treatment with pretrial case processing cannot work unless the treatment program can disclose information about defendants to the criminal justice system.

Research evaluating the efficacy of these programs also requires that substance abuse programs disclose data about their patients to others. Policymakers considering whether to fund a program will want to know whether it works. The long-term survival of drug courts depends on good research, based on good data.

Programs designed to integrate substance abuse treatment with pretrial case processing cannot work unless the treatment program can disclose information about defendants to the criminal justice system.

Federal Restrictions on Disclosure of Information About Patients

Although the flow of information from the substance abuse treatment program to the criminal justice system and to the researcher/evaluator is critical, those planning or operating programs and research studies must keep in mind that Federal laws and regulations protect information about all persons receiving alcohol and drug abuse prevention and treatment services (42 U.S.C. Section 290dd-3 and ee-3 and 42 Code of Federal Regulations, Part 2).2 These laws and regulations prohibit disclosure of information regarding patients who have applied for or received any alcohol or drug abuse-related services, including assessment, diagnosis, counseling,

group counseling, treatment, or referral for treatment, from a covered program. The restrictions on disclosure apply to any information that would identify a patient as an alcohol or drug abuser, either directly or by implication. They apply to patients who undertake treatment as a form of alternative processing, patients who are civilly or involuntarily committed, minor patients, and former patients. They apply even if the person making the inquiry already has the information, has other ways of getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena or search warrant.

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for patients with alcohol or drug problems must comply with the Federal confidentiality regulations (Section 2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this category includes organizations that receive indirect forms of Federal aid such as tax-exempt status, or State or local funding coming (in whole or in part) from the Federal government.

The Importance of Obtaining Defendants' Consent to Disclosure of Information

Information that is protected by the Federal confidentiality laws and regulations may always be disclosed after the defendant has signed a proper consent form.3 The Federal regulations also permit disclosure without the defendant's consent in several limited situations, including medical emergencies, under a court's special authorizing order, and in communication among substance abuse treatment program staff.4

Disclosures to the criminal justice partner are permissible once a defendant has signed a criminal justice system consent form (Section 2.35).5 An example of this form is presented in Exhibit 8-1. This form must be in writing and must contain each of the following items:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the patient who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement regarding revocation of consent
- The date, event, or condition upon which the consent will expire
- The signature of the patient
- The date on which the consent is signed.

The requirements regarding consent are somewhat unusual and strict but must be carefully followed. A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable.

Limitations on Disclosure

All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (Section

2.13(a)). It would be improper to disclose everything in a defendant's file if the recipient of the information needs only one specific piece of information.

The purpose or need for the communication of information must be indicated on the consent form. Once this material has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose that has been identified.

The kind and amount of information disclosed to the criminal justice system by a treatment program will depend on the structure of the collaborative program. For example, in the drug court model, the judge, prosecutor, and defense counsel see the defendant frequently to offer words of encouragement or criticism in response to the defendant's performance. In this model, the purpose of the disclosure would be "to provide information about performance in treatment" and the kind and amount of information would be "drug test results, attendance at the program, and counselor's assessment."

Information that is protected by the Federal confidentiality laws and regulations may always be disclosed after the defendant has signed a proper consent form.

Seeking Information From Collateral Sources

When a substance abuse treatment program that screens, assesses, or treats criminal defendants asks relatives, doctors, employers, or school representatives about defendants, it is making a patient-identifying disclosure. In other words, when treatment program staff seek information from other sources, they are letting these sources know that the defendant is being considered for substance abuse treatment. The Federal regulations generally prohibit this kind of disclosure unless the patient consents.

The substance abuse treatment program can proceed in one of two possible ways. First, if the criminal justice partner makes the inquiries without mentioning substance abuse or treatment, there is no disclosure of the defendant's substance abuse and therefore no violation of the confidentiality rules has occurred. The second way, of course, is to get the defendant's consent to contact the relative, doctor, employer, school, health care facility, etc.

The Duration of Consent

The criminal justice system consent form must contain a date, event, or condition upon which it will expire. The Federal confidentiality regulations permit the criminal justice system consent to be irrevocable until this specified date or condition occurs.6 Thus, a defendant entering treatment in lieu of prosecution or punishment cannot prevent the court or other agency from monitoring his or her progress (see Exhibit 8-1.) The regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the defendant is involved
- The need for treatment information in dealing with the proceeding
- The expected date of final disposition
- Anything else the patient, program, or criminal justice agency believes is relevant.

These rules allow programs to continue to use as a traditional expiration condition for a consent form the phrase "when there is a substantial change in the patient's justice system status."

Prohibitions on Redisclosing Information

Information obtained from a substance abuse treatment program through a patient's consent cannot be redisclosed unless permitted by the regulations (Section 2.32). The Federal confidentiality regulations require that disclosures made with written patient consent be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information. This statement should be delivered and explained to the recipient at the time of disclosure or earlier (see Exhibit 8-2).

Using Criminal Justice System Consent Forms

Whenever possible, it is best to have a proper criminal justice system consent form signed by the defendant before he or she is referred to the treatment program. If that is not possible, the treatment program should have the defendant sign a criminal justice system consent form at his or her very first appointment.

If a program fails to have the defendant sign a criminal justice system consent form and the defendant fails to complete the assessment process or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. It is unclear whether a court can issue an order under Section 2.65 that would authorize the program to release information about a referred defendant who has left the program in this type of case. This is because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only where a crime has been committed that is "extremely serious." Absconding from a program generally will not meet that criterion.

Therefore, unless a consent form is obtained by the judge or criminal justice agency or by the substance abuse treatment program at the beginning of the assessment or treatment process, the program could be prevented from providing any information to the court or to another criminal justice agency that referred the defendant.

If the defendant referred to treatment program by one court or another criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without patient consent (Section 2.13(c)(2))

Information About Patients

As discussed previously in this TIP, it is essential in the planning stages of an alternative processing program that the criminal justice and treatment partners reach agreement about communications between the program and the criminal justice agency. Clear guidelines must be established: How detailed will the program's reports be? Will the program report specific treatment information, as is done in some drug courts, or only limited information? And how will the criminal justice system use the information?

These issues raise the question of fairness: For example, will the prosecutor and court be able to use information obtained from the substance abuse treatment program against a defendant who fails to complete treatment? Would such use violate the Federal laws and regulations? Finally, could a treatment program function if the negative information it obtains in the course of treatment could be used against a defendant at a later date?

Will the prosecutor and court be able to use information obtained from the substance abuse treatment program against a defendant who fails to complete treatment?

The issue of program viability is inextricably linked with the question of fairness. In order to provide counseling, programs must obtain information about their patients' lives, feelings, and thoughts. Substance abuse treatment providers hear a great deal of negative information about their patients, whether or not their patients are involved in the criminal justice system. It would be virtually impossible for programs to function if patients felt constrained about disclosing such information. To increase the punishment of defendants, either by adding charges for new offenses or by increasing punishment in light of newly discovered evidence, as a result of disclosures they made while in treatment would be both unfair and counterproductive.

Defendants should also be informed about what kind of information will be disclosed to the court and other justice systems agencies, how often it will be disclosed, and how it will be used. The criminal justice system consent form signed by the defendant should detail the kinds of information that will be disclosed to the justice system. The Federal confidentiality regulations also require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. (The regulations contain a sample notice.) The notice and summary should be handed to patients when they begin participating in the program or soon thereafter (Section 2.22(a)).

The Implications of Computerization

Computerizing the flow of information between the substance abuse treatment provider and the courts allows the system to react promptly to information from the treatment provider. For example, judges with immediate access to the attendance records and drug testing results entered by the treatment provider can quickly reward or sanction improvements or slips in the

defendant's behavior. Computerization also reduces the number of times the same information is gathered and recorded.

Computerization of communications between the substance abuse program and its criminal justice partners does create some confidentiality problems. A disclosure of protected information occurs each time someone "accesses" a file from a computer. Unless appropriate safeguards are built into the software, computerization can undermine the controls on disclosure that are inherent in requiring the patient to sign a consent form before each disclosure to a new person or entity.

Computerizing the flow of information between the substance abuse treatment provider and the courts allows the judge to promptly reward or sanction a defendant's improvement or slip.

Computerization carries a risk that treatment information entered by the substance abuse treatment provider will be obtained by a person or entity not authorized to obtain it. Security of computer systems with telephone links between the treatment and justice system partners must be safeguarded.[7] The treatment provider also must take care that the information entered into the computer is limited to that which it is authorized to disclose according to the defendant's consent form. Finally, computerization carries the risk that information about the defendant will remain accessible after the defendant has left the system and the consent form has expired. Programs planning to computerize must devise a way to delete all substance abuse information about a defendant once his or her consent form expires.

Coding Patients' Names

The Federal confidentiality regulations protect "patient identifying information." Section 2.11 of the regulations defines this to mean the name, address, Social Security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of or contain numbers that could be used to identify a patient with reasonable accuracy and speed from sources external to the program (such as Social Security or driver's license number).

Responding to Patients' Disclosures of Criminal Activity

Reporting Threatened Activity: The Duty to Warn

For most treatment professionals, the issue of reporting a patient's threat or intention to commit a crime is a troubling one. Many professionals feel that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is

a serious one. In working with defendants, substance abuse treatment practitioners may face questions about their "duty to warn" someone of a patient's threat to harm another.

A recent trend in the law requires psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another."

There are five ways a substance abuse treatment program participating in alternative processing can proceed when patients threaten to harm others or themselves.

- The program can make a report to the court or other criminal justice agency that is its partner in the program, as long as there is a criminal justice system consent form signed by the defendant that is worded broadly enough to allow this sort of information to be disclosed. The criminal justice agency can then act on the information by warning the intended victim or notifying another law enforcement agency of the threat. However, in doing so, the criminal justice agency must be careful that no mention is made that the source of the information was a substance abuse program or that the defendant is in substance abuse assessment or treatment. (Disclosures that do not identify the defendant as someone with a substance abuse problem are permitted. See Section 2.12(a)(1).)
- The substance abuse treatment program can go to court and request a court order in accordance with Section 2.64 of the Federal regulations, authorizing the disclosure to the intended victim, or in accordance with Section 2.65, authorizing disclosure to a law enforcement agency.8
- The substance abuse treatment program itself can make a disclosure to the potential victim or law enforcement officials that does not identify as a patient the individual who threatens to commit the crime. This can be accomplished either by making an anonymous report or, for a substance abuse treatment program that is part of a larger non-drug/alcohol entity, by making the report in the larger entity's name.
- The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical intervention (Section 2.51). Thus, for example, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged.
- The program can obtain the patient's consent.9

If none of these options is practical, what should a treatment program do? It is, after all, confronted with conflicting moral and legal obligations. If a substance abuse treatment program believes there is clear and imminent danger to a patient or a particular other person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual.

As in other areas where the law is still developing, treatment programs should find a lawyer familiar with the issues, who can provide advice on a case-by-case basis. "Duty to warn" issues also present an area in which staff training, as well as a staff review process may be helpful.

Reporting Past Criminal Activity

What should a substance abuse treatment program do when a patient tells a counselor, for example, that she intends to get her children new clothes by shoplifting, a crime the counselor knows she has committed many times in the past? Does the program have a duty to tell the police? Does a program have a responsibility to call the police (or its criminal justice partner) when a patient discloses to a counselor that he participated in a crime some time in the past, or during his participation in the program? What can a treatment program do when a patient commits a crime at the program or against an employee of the program? These are three very different questions that require separate analysis.

A substance abuse treatment program generally does not have a duty to warn another person or the police about a patient's intended actions unless the patient presents a serious danger of violence to an identifiable individual. Shoplifting rarely involves violence, and it is unlikely that the counselor will know which stores are to be victimized. Petty crime like shoplifting is an important issue that should be dealt with therapeutically. It is not something a substance abuse program should necessarily report to the police.

Suppose, however, that a patient admits during a counseling session that he killed someone during a robbery three years ago. Does the program have a responsibility to report that? And is the answer any different if the defendant admits he or she committed a serious crime while participating in treatment as part of an alternative processing agreement?

In a situation in which a patient has told a counselor that he or she committed a crime in the past, there are generally three questions the substance abuse program needs to ask as it considers whether to make a report:

Is there a legal duty to report the past criminal activity to the police under State law? The answer to his question varies from State to State. In most States, however, there is no legal duty to report a crime committed in the past to the police.

Does State law permit a counselor to report the crime to law enforcement authorities if he or she wants to? Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, State law may protect conversations between counselors of substance abuse treatment programs and their patients and exempt counselors from any requirement to report past criminal activity by patients. Such laws are important to patients in substance abuse treatment, many of whom have committed offenses. Part of these patients' therapeutic process is acknowledging the harm they have done others. If substance abuse treatment programs routinely reported patients' admissions of past criminal activity to the police, their work with patients in the recovery process would be thwarted. Laws protecting conversations between counselors of substance abuse programs and their patients are designed to protect the special relationship that substance abuse counselors have with their patients, as well as the treatment process.

State laws vary widely in the protection they accord communications between patients and counselors. In some States, admissions of past crimes may be considered privileged, and counselors may be prohibited from reporting them; in others, admissions may not be privileged.

Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend upon the type of professional the counselor is and whether he or she is licensed or certified by the State.

If State law requires a report (or permits one and the program decides to make a report), how can the substance abuse treatment program comply with the Federal confidentiality regulations and State law? Any substance abuse treatment program that decides to make a report to law enforcement authorities about a patient's prior criminal activity must do so without violating either the Federal confidentiality regulations or State laws. A program that decides to report a patient's crime can comply with the Federal regulations by following one of the first three methods described above in the discussion of "Duty to Warn":

- If the patient is a defendant participating in a drug court program, the substance abuse agency can make a report to the court or other appropriate criminal justice partner, if it has a criminal justice system consent form signed by the patient that is worded broadly enough to allow this sort of information to be disclosed.
- The substance abuse treatment program can make a report in a way that does not identify the individual as a patient.
- The treatment program can obtain a court order under Section 2.65 of the regulations, permitting it to make a report if the crime is "extremely serious."

By using any one of these methods, the substance abuse program will have discharged its reporting responsibility without violating the Federal regulations. However, the law enforcement agency that receives the report is prohibited by the regulations from investigating or prosecuting a patient based on information obtained from a substance abuse program, that is unless the court order exception is used (42 U.S.C. Section 290 dd-3(c) and ee-3(c) and 42 C.F.R. Section 2.12(d)(1)). Because of the complicated nature of this issue, any program considering reporting a patient's admission of criminal activity that occurred in the past should seek the advice of a lawyer familiar with local law as well as the Federal regulations. For a discussion about how programs can deal with search and arrest warrants, see TIP 19, *Detoxification from Alcohol and Other Drugs*, p. 83 (CSAT, 1995).

Reporting Current Criminal Activity

What should the treatment program do if a defendant it is treating admits to committing a crime during treatment? Smooth operation requires trust between the partners and there is nothing more destructive of trust between the substance abuse treatment system and the criminal justice system than misunderstanding and disagreement on this issue.

To ensure that no misunderstandings occur, the substance abuse treatment program and the justice system participants should agree in writing about whether criminal activity will be reported and, if so, what kinds of activity. They should decide how much discretion the program will use in dealing with criminal activity as a therapeutic issue.

In coming to an agreement on this issue, the substance abuse treatment program and the criminal justice system must balance the goal of public safety with the goal of individual recovery. Those concerned with public safety will generally advocate drawing the line at a point that requires greater reporting of criminal activity by the treatment program. Those concerned with the effectiveness of treatment programs may argue that reporting of criminal activity must be limited if defendants are to continue to communicate freely in recovery.

Wherever the line is drawn, it is essential that the defendants participating in a drug court program be informed that their admissions of criminal activity committed during treatment will be reported. The criminal justice system consent form that defendants sign should make clear that certain kinds of ongoing criminal activity will be reported promptly to the court and/or prosecutor.

It is important to recognize that the Federal regulations strictly prohibit any investigation or prosecution of a patient based on information obtained from a substance abuse treatment program unless the Section 2.65 court order exception is used (42 U.S.C. Sections 290 dd-3 and ee-3 and 42 C.F.R. Section 2.12(d)(1)). For this reason, those creating programs should consider providing treatment providers with the capacity to apply for a court order under Section 2.65 of the Federal regulations in cases where patients commit serious crimes. All that is required is a model set of legal papers that the program can submit to the appropriate court on a moment's notice. This will permit prompt reporting of crimes that threaten public safety and that call for separate investigation and prosecution.

When a patient has committed or threatens to commit a crime on treatment program premises or against program personnel, the regulations permit the treatment program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the individual's name, address, last known whereabouts, and status as a patient at the program (Section 2.12(c)(5)).

Conducting Research in Accordance With Confidentiality Laws and Regulations

Chapter 6 discussed evaluation efforts that can be helpful in assessing the effectiveness, operations, and impact of programs integrating substance abuse and pretrial case processing. Because research on criminal justice or substance abuse treatment programs usually entails the gathering of information about individual clients, there are a number of confidentiality regulations and procedures that must be followed. This section offers guidelines for following these regulations when conducting research on these types of programs.

Research about and evaluation of the efficacy of programs is essential if existing ones are to continue to receive funding and if new programs are to be developed. The Federal confidentiality regulations provide three ways for substance abuse treatment programs to share information with researchers.10

- The regulations permit programs to give researchers access to information about patients when no patient identifying information is revealed.
- The regulations permit programs to give researchers patient identifying information without patients' consent when certain criteria are met.
- Researchers may also obtain information that is protected by the Federal confidentiality regulations if patients sign proper consent forms.

Access to Data Not Containing Patient Identifying Information

The Federal regulations permit programs to disclose information about patients if the program reveals no patient identifying information (Section 2.12(a)(1)). "Patient identifying information" is information that identifies specific individual as an alcohol or drug abuser. Thus, a program can give researchers aggregate data about its population or some portion of its population. For example, a program could tell a researcher that during the past year, 42 patients completed treatment, 67 dropped out in less than 6 months, and 25 left between 6 and 12 months.

Use of Patient Identifying Information for Research, Audit, and Evaluation

Nonconsensual Use of Information

The Federal confidentiality regulations permit programs to disclose patient identifying information to researchers, auditors, and evaluators without patient consent, providing that certain safeguards are in place (Section 2.52; Section 2.53).

Research. Substance abuse treatment programs can disclose patient-identifying information to persons conducting "scientific research" if the treatment program director determines that the researcher is qualified to conduct the research; has a protocol under which patient identifying information will be kept confidential in accordance with the regulations' security provisions (see Section 2.16); and has provided a written statement from a group of three or more independent individuals (such as an Institutional Review Board) that have reviewed the protocol and determined that it protects patients' rights. Researchers are prohibited from identifying any individual patient in any report or otherwise disclosing any patient identities except back to the program.

Audit and evaluation. Federal, State, and local government agencies that fund or are authorized to regulate a substance abuse treatment program, private entities that fund or provide third party payments to a program, and peer review entities performing a utilization or quality control review may review patient records on the program's premises in order to conduct an audit or evaluation. 11 Any person or entity that reviews patient records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose patient information only back to the program; in accordance with a court order to investigate or prosecute the program (Section 2.66); or to a government agency overseeing a Medicare or Medicaid audit or evaluation (Section 2.53(a), (c), (d)). Any other person or entity who the program director deems qualified to conduct an audit or evaluation and who agrees in writing to abide by the restrictions on redisclosure can also review patient records.

Use of Information Obtained With Patients' Consent

Researchers can also obtain patient identifying information if the patient has signed a valid consent form that has not expired or been revoked (Section 2.31). This consent form differs from the criminal justice system consent form, in two respects(see Exhibit 8-3). First, the defendant may revoke the consent at any time and the consent form must contain a statement to this effect. (However, if a program has already given information to a researcher prior to the revocation, it need not try to retrieve the information it has already disclosed.) Revocation by the patient need not be in writing.

Second, the consent form must contain a date, event, or condition upon which it will expire if not previously revoked. Section 2.31(a)(9) provides that the consent must "last no longer than reasonably necessary to serve the purpose for which it is given."

Followup Research

Research that follows patients for any period of time after they leave treatment presents a special challenge. Under the Federal regulations, no information that the researcher or evaluator gained from the substance abuse treatment program with the patient's consent or through the research, audit, and evaluation exceptions may be disclosed to anyone else. Yet the researcher must locate the patient in order to collect followup data.

To ensure that patients can be located after they leave treatment, researchers sometimes ask for the names of persons with whom the patients are likely to have continued contact. Making inquiries of these persons in order to locate a former patient might seem at first glance to pose no risk to a patient's right to confidentiality. However, confidentiality is just as essential in these types of communications. For example, if someone from a research entity called a former patient's relative or friend to locate the former patient, the fact he or she had been in treatment might well be revealed. The Federal regulations clearly prohibit this kind of disclosure without the patient's consent. Thus researchers and evaluators trying to locate a patient must do so without disclosing to others any information about the patient's connection to substance abuse treatment or they must obtain the patient's consent to do so.

If followup contact is attempted over the telephone, the caller must ascertain that he or she is indeed talking to the patient before identifying himself or herself or mentioning a connection to the substance abuse treatment program. The program (or research agency) may form another entity, without a hint of its substance abuse focus in its name (for example, Health Research, Inc.), that can contact former patients without worrying about disclosing information simply by giving its name. However, the representative of such an entity calling former patients still must be careful that the patient is on the line before revealing any connection to the program. It is a good idea for the research entity to have a set of scripted answers that the caller can use when questioned about the purpose of the inquiry. If followup is to be done by mail, the return address should not disclose any information that could lead someone to conclude that the addressee was in treatment.

Followup With Collateral Sources

Research or evaluation that collects data about patients from collateral sources raises a similar issue to that raised by followup with patients themselves. How can an inquiry be made of relatives (including parents), employers, schools, or social welfare agencies without violating the Federal regulations?

There are two ways to approach this problem. First, the researcher can structure the data-gathering to avoid revealing that the patient was in treatment. To accomplish this, the name of the entity that conducts the research must be neutral, revealing nothing about a substance abuse connection. The questions asked of the collateral sources must also be phrased so that they offer those sources no information that would directly or implicitly link the patient with substance abuse or treatment.

The second way a researcher can gather information from collateral sources is to obtain the patient's consent to disclose to the collateral source the fact that the patient was in treatment for substance abuse. The special consent form required by Section 2.31 of the regulations must be used. As outlined above, this form must include the purpose of the disclosure, in this instance, research, and how much and what kind of information will be disclosed, in this instance, the fact that the patient was in substance abuse treatment. The form also must include an expiration date and a statement that consent can be revoked at any time.

Using a consent form to gather information from collateral sources may require more work initially, but it provides more freedom to the researcher. With consent forms signed by patients, the researcher may ask questions about current alcohol or other drug use. However, he or she still must take care to reveal only the limited information allowed by the consent form. The researcher should have a system to keep track of the expiration dates of the consent forms.

Coding Patients' Identities

If a researcher codes patients' names to protect their identities, can some of the intricate rules of the Federal confidentiality regulations be disregarded? It depends. As noted above, the Federal regulations protect "patient identifying information." If a researcher can code patients' names so that the number created for each patient cannot be "used to identify a patient with reasonable accuracy and speed from sources external to the program," the researcher need no longer be concerned with safeguarding information about the patient.

Voluntariness

One of the concerns sometimes raised about treatment drug courts is that they "force" the defendant into treatment by offering a choice between treatment and conventional prosecution that would be likely to result in more onerous restrictions on the defendant's liberty. Critics contend that coerced treatment is unethical and, on a more pragmatic note, may also add that treatment, which is supposed to help empower people, is unlikely to be successful if the defendant did not freely choose to participate.

One response to this criticism is that it is based on a false premise, in the case of defendants who are in the pretrial stages of criminal case processing. As noted in Chapter 1, a pretrial defendant cannot be compelled to participate in any real treatment program. The decision about participation is the defendant's alone. It is a decision that should ordinarily be made after consultation with a defense lawyer who can explain the legal situation to the defendant and help protect all of the defendant's legal rights.

A second response is one that, at least in some instances, defendants may choose the treatment option because it appears less onerous than conventional prosecution. In that sense, there may be an element of "coercion" underlying the defendant's decision to enter treatment. However, it is common for substance abusers to enter treatment not simply because they want to stop abusing drugs but because someone, a spouse, an employer, a doctor, or another significant figure, has given them to an ultimatum -- obtain treatment "or else." The possibility of a return to conventional prosecution is the justice system's "or else" for programs that integrate substance abuse treatment and pretrial cases processing. Furthermore, treatment has been proven to be more effective if the client stays with it for more than 90 days, so the "coercion" actually improves the substance abusers' chances of overcoming their addiction or related problem.

The authority of the court and/or the prosecutor's office to resume conventional prosecution in the case that a defendant fails to comply with the program's conditions is undoubtedly an important incentive for keeping defendants in treatment, particularly at the outset of a treatment regimen. Treatment is rarely an easy or comfortable experience, and the dropout rates of many substance abuse treatment programs are high.

Endnotes

1 This chapter was written for the Consensus Panel by Margaret K. Brooks, Esq.

2 Hereinafter, citations in this section in the form "Section 2..." refer to specific sections of 42 C.F.R., Part 2, implementing the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. Section 290dd-3) and the Drug Abuse Prevention, Treatment, and Rehabilitation Act (42 U.S.C. Section 290ee-3).

3 If the offender is a minor, parental consent must also be obtained in some States. This issue is discussed in more detail in TIP 3, Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents (CSAT, 1993a).

4 For detailed discussion of exceptions to nondisclosure regulations, see TIP 19, Detoxification from Alcohol and Other Drugs (CSAT, 1995).

5 Note, however, that no information obtained from a program (even if the patient consents) may be used in a criminal investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in Section 2.65 (42 U.S.C. Section 290dd-3(c), ee-3(c); 42 C.F.R. Section 2.12(a), (d)).

6 This is a key difference between the criminal justice system consent form and the general consent form authorized by the Federal regulations, which permits the offender to revoke consent at any time. See the discussion about the general consent form below.

7 Security of the computer system is especially important in view of the security requirements of the

Federal regulations. Section 2.16 provides:
(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and
(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations."
8 The regulations limit disclosures to law enforcement agencies for the purpose of investigating or prosecuting a patient to "extremely serious" crimes, "such as one which causes or directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect." (Section 2.65). For a discussion of the court order exceptions, see TIP 7, Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System (CSAT, 1994a).
9 Note that Federal confidentiality statutes and regulations strictly prohibit any investigation or prosecution of a patient based on information obtained from records unless the court order exception is used. 42 U.S.C. Section 290 dd-3(c) and ee-3(c) and 42 Section 2.12(d)(1).
10 In addition to the Federal confidentiality laws and regulations discussed in this section, two other Federal statutes permit the United States Attorney General and the Secretary of Health and Human Services (HHS) to issue "confidentiality certificates" to researchers. Once a certificate is issued, the researcher "may not be compelled in any Federal, State or local civil, criminal, administrative, legislative or other proceeding to identify the subjects of research for which such authorization was obtained." See 42 U.S.C. Section 241(d) (permitting the Secretary of HHS to issue confidentiality certificates) and 21 U.S.C. Section 872(c) (permitting the Attorney General to do so).
11 These entities may also copy or remove records, but only if they agree in writing to maintain patient identifying information in accordance with the regulations' security requirements (see Section 2.16) to destroy all patient identifying information when the audit or evaluation is completed, and to redisclose patient information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (Section 2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (Section 2.53(b)).

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Appendix A -- Bibliography

Agopian, M.W.

Politics of evaluating diversion programs. Evaluation Quarterly 1979; 3(1):81-88.

Ali, B.E.

The International Prisoners Aid Association and drug abuse control. Bulletin on Narcotics 1991; 43(1):3-7.

American Prosecutors Research Institute, National Drug Prosecution Center and the Bureau of Justice Assistance.

Beyond Convictions. Prosecutors as Community Leaders in the War on Drugs. Chapter 4: Diversion to Treatment. 1993.

Annas, G.J.

Control of tuberculosis:the law and the public's health. New England Journal of Medicine 1993; 328(8):585-588.

Belenko, S. and Dumanovsky, T.

Special drug courts: program brief. Washington, DC: Bureau of Justice Assistance; 1993.

Bickell, N.A., Vermund, S.H., Holmes M., Safyer, S., and Burk, R.D.

Human papillomavirus, gonorrhea, syphilis, and cervical dysplasia in jailed women. American Journal of Public Health 1991; 81(10):1318-1320.

Brochu, S. and Levesque, M.

Treatment of prisoners for alcohol or drug abuse problems. Alcoholism Treatment Quarterly 1990; 7(4):113-121.

Brownstone, D.Y., and Swaminath, R.S.

Violent behaviour and psychiatric diagnosis in female offenders. Canadian Journal of Psychiatry 1989; 34(3):190-194.

Bureau of Justice Assistance.

Differentiated Case Management. Bureau of Justice Assistance Fact Sheet. Washington, DC: Bureau of Justice Assistance; Nov 1995.

Califano, J.A.

The Three-Headed Dog from Hell: The Staggering Public Health Threat Posed by AIDS, Substance Abuse, and tuberculosis. Washington Post, December 21, 1992, p. A21.

California Center for Judicial Education and Research.

Drug Courts: A Judicial Manual. California Center for Judicial Education and Research; Summer 1994, pp. 16-17.

Center for Substance Abuse Treatment.

Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 93-2009; 1993a. Treatment Improvement Protocol (TIP) Series 3.

Center for Substance Abuse Treatment.

Screening for Infectious Diseases Among Substance Abusers . Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 93-2048; 1993b. Treatment Improvement Protocol (TIP) Series 6.

Center for Substance Abuse Treatment.

Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of

Health and Human Services publication SMA 94-2076; 1994 a. Treatment Improvement Protocol (TIP) Series 7.

Center for Substance Abuse Treatment.

Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 94-2078; 1994 b. Treatment Improvement Protocol (TIP) Series 9.

Center for Substance Abuse Treatment.

Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 94-2094; 1994 c. Treatment Improvement Protocol (TIP) Series 11.

Center for Substance Abuse Treatment.

Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 94-3004; 1994 d. Treatment Improvement Protocol (TIP) Series 12.

Center for Substance Abuse Treatment.

Detoxification from Alcohol and Other Drugs. Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 95-3046; 1995 . Treatment Improvement Protocol (TIP) Series 19.

Centers for Disease Control and Prevention.

Initial Therapy for Tuberculosis in the Era of Multidrug Resistance: Recommendations of the Advisory Council for the Elimination of Tuberculosis. Journal of the American Medical Association 1993; 270(6):694-698.

Chicago Health Policy Research Council.

Analysis of the Structure of State Medicaid Managed Care Programs. Chicago, IL: Chicago Health Policy Research Council; May 1994.

Covell, R.G., et al.

Prison experience of injecting drug users in Glasgow. Drug and Alcohol Dependence 1993; 32(1):9-14.

Dignan, J.

Repairing the damage: Can reparation be made to work in the service of diversion? British Journal of Criminology 1992; 32(4):453-472.

Dubler, N.N. and Sidel, V.W.

On research on HIV infection and AIDS in correctional institutions. The Milbank Quarterly 1989; 67(2):171-207.

Du Toit, L. and Duckitt, J.

Psychological characteristics of over- and undercontrolled violent offenders. The Journal of Psychology 1990 ; 124(2):125-141.

Dutton, D.G., and Hart, S.D.

Risk markers for family violence in a federally incarcerated population. International Journal of Law and Psychiatry 1992; 15(1):101-112.

Finn, P. and Newlyn, A.K.

Dade County Diverts Drug Defendants to Court-Run Rehabilitation Program. In Miami's Drug Court: A Different Approach. Washington, DC: National Institute of Justice; June 1993 .

Fraboni, M., Cooper, D., Reed, T.L., and Saltstone, R.

Offense type and two-point MMPI code profiles: discriminating between violent and nonviolent offenders. Journal of Clinical Psychology 1990; 46(6):774-777.

Friday, P.C., Malzahn-Bass, K.R., and Harrington, D.K.

Referral and selection criteria in deferred prosecution. British Journal of Criminology 1981; 21(2):166-172.

Gerstein, D.R., Harwood, H.J.

The effectiveness of treatment. In: Institute of Medicine, Treating Drug Problems. Washington, DC:National Academy Press; 1990.1:132-199.

Goldkamp, J.

Justice and Treatment Innovation: The Drug Court Movement . Washington, DC: National Institute of Justice and the State Justice Institute; December 1993.

Goldkamp, J.S. and Weiland, D.

Assessing the Impact of Dade County's Felony Drug Court . Washington, DC: National Institute of Justice; 1993 .

Gottheil, D.L.

Pretrial diversion: a response to the critics. Crime and Delinquency 1979; 65-75.

Grobsmith, E.S. and Dam, J.

The revolving door: substance abuse treatment and criminal sanctions for Native American offenders. Journal of Substance Abuse 1990; 2(4):405-425.

Health Care Financing Administration, Medicaid Bureau.

National Summary of State Medicaid Managed Care Programs . Washington, DC: U.S. Department of Health and Human Services; June 30, 1993.

Heilbrun, A.B., Jr.

The measurement of criminal dangerousness as a personality construct: further validation of a research index. Journal of Personality Assessment 1990; 54(1-2):141-148.

Heimberger, T.S., et al.

High prevalence of syphilis detected through a jail screening program: A potential public health measure to address the syphilis epidemic. Archives of Internal Medicine 1993 ; 153(15):1799-1804.

Inciardi, J.A., et al.

Assertive community treatment with a parolee population: an extension of case management.

Johnsen, C.

Tuberculosis contact investigation: two years of experience in New York City correctional facilities. American Journal of Infection Control 1993; 21(1):1-4.

Kirk, A.

The prediction of violent behavior during short-term civil commitment. Bulletin of the American Academy of Psychiatry Law 1989; 17(4):345-353.

Lake, E.S.

An exploration of the violent victim: experiences of female offenders. Violence and Victims 1993; 8(1):41-51.

Leukefeld, C.G. and Tims, F.R.

Drug abuse treatment in prisons and jails. Journal of Substance Abuse Treatment 1993; 10(1):77-84.

Lipscher, R.D.

The Judicial Response to the Drug Crisis: Report of an Executive Symposium Involving Judicial Leaders of the Nation's Nine Most Populous States. State Court Journal 1989; 13:13-14.

McKay, J.R., Murphy, R.T., McGuire, J., Rivinus, T.R., and Maisto, S.A.

Incarcerated adolescents' attributions for drug and alcohol use. Addictive Behaviors 1992; 17(3):227-235.

National Association of Pretrial Services Agencies.

Performance Standards and Goals for Pretrial Release and Diversion. Position paper. Washington DC: National Association of Pretrial Services Agencies, August 1978.

Patel, K.K., Hutchinson, C., and Sienko, D.G.

Sentinel surveillance of HIV infection among new inmates and implications for policies of corrections facilities. Public Health Reports 1990; 105(5):510-514.

Peters, R.H., and Kearns, W.D.

Drug abuse history and treatment needs of jail inmates. American Journal of Drug and Alcohol Abuse 1992; 18(3):355-366.

President's Commission on Model State Drug Laws. Vol. IV.

Model Criminal Justice Treatment Act. Washington, DC: The White House; 1993: G-141-149.

Prochaska, J.O., DiClemente, C.C., and Norcross, J.C.

In search of how people change: applications to addictive behaviors. American Psychologist 1992; 47(9):1102-1114.

Rebovich, D.

Evaluation of deferred prosecution programs. Washington, DC: Bureau of Justice Assistance.

Robles, R.R., Marrero, C.A., Freeman, D.H., Colon, H.M.; Matos, T.D., and Sahai, H.

Incarceration history as a risk factor for HIV infection among Puerto Rican injection drug users. Puerto Rican Health Science Journal 1993; 12(1):13-17.

Rosenberg, M.L., O'Carroll, P.W., and Powell, K.E.

Let's be clear - violence is a public health problem.Journal of the American Medical Association 1992; 267(22):3071-3072.

Rosenthal, M.S.

The therapeutic community: exploring the boundaries. British Journal of Addiction 1989; 84:141-150.

Smith, B.E., Davis, R.C., and Goretsky, S.R.

Strategies for Courts to Cope with the Caseload Pressures of Drug Cases: Executive Summary. Chicago IL: American Bar Association; 1991.

Stevens, N.M.

Diversion to treatment background information. Washington DC: Bureau of Justice Assistance, U.S. Department of Justice.

Thorne, S.

Education the main weapon as prison officials defend against AIDS threat. Canadian Medical Association Journal 1992; 146(4):573-580.

Turnbull, P.J., Dolan, K.A., and Stimson, G.V.

HIV testing, and the care and treatment of HIV positive people in English prisons. AIDS Care 1993; 5(2):199-206.

van Hoeven, K.H., Stoneburner, R.L., and Rooney, W.C.

Drug use among New York City prison inmates: a demographic study with temporal trends. International Journal of the Addictions 1991; 26(10):1089-1105.

Viadro, C.I. and Earp, J.

AIDS education and incarcerated women: a neglected opportunity. Women & Health 1991;17(2):105-117.

Vigdal, G.

Comprehensive assessment, diagnosis and classification: treatment matching of substance abusing offenders. National Advisory Commission on Criminal Justice Standards and Goals (1973) Report on Corrections. Washington DC: U.S. Department of Justice; 1973: 352-357.

Weiner, J. and Anno, B.J.

The crisis in correctional health care: the impact of the National Drug Control Strategy on Correctional Health Services. Annals of Internal Medicine 1992; 117(1):71-75.

Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing

Treatment Improvement Protocol (TIP) Series 23

Appendix B -- Federal Resource Panel

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Exhibits

Exhibit 1-1 Examples of Systems Integration

In the District of Columbia and Multnomah County, Oregon, "supervised release" or "conditional release mechanisms" operate to release defendants from pretrial custody under conditions that include regular or random urine testing, graduated sanctions, and participation in a substance abuse treatment program."
The Dade County, Florida, program involves acceptance into a drug court treatment program shortly after arrest, with an understanding that further prosecution will be held in abeyance, and if the defendant successfully completes the program, the charges will be dropped.
Pensacola, Florida has a "deferred judgment" program or "post-plea diversion" program shortly after arrest, under which the defendant pleads guilty to a criminal charge (for example, unlawful possession of drugs) with the understanding that sentence will be deferred. If the defendant successfully completes the program, the plea of guilty will be vacated and the charges dropped, but if the defendant fails to complete the program, sentence will be based on the original charge.

Exhibit 2-1 Traditional Court Characteristics Versus Drug Court Characteristics

Traditional Court	Drug Court
Court team of judge, prosecutor, defense counsel, etc	New court team created to achieve goals of supportive treatment interventions
Adversarial	Non-adversarial
Goal = Process case; apply the law	Goal = Restore defendant as a productive, non-criminal member of society

Judge exercises limited role in supervision of defendant	Judge plays central role in monitoring defendant's progress in treatment
Interventions for substance abuse at discretion of judge	Formalized and structured treatment interventions
Relapse may lead to increased sentence	Graduated sanctions used to respond to lapses in drug court program conditions

Exhibit 8-1 Consent for the Release of Confidential Information

Exhibit 8-1

Consent for the Release of Confidential Information:

Criminal Justice System Referral

I, _____
(Name of defendant),
hereby consent to communication between _____

(treatment program)
and_____
(Court, probation, parole, and/or other referring agency)
the following information:

_____
(Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agencies listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and I understand that this consent will remain in effect and cannot be revoked by me until:

	There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or
	(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

(Date)	(Signature of defendant/patient)
	(Signature of parent, guardian, guardian, or authorized representative if required)

Exhibit 8-2 Prohibition on Re-disclosing Information

Prohibition on Re-disclosing Information
Concerning AOD Abuse Treatment Patients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Exhibit 8-3 Consent for the Release of Confidential Information

Consent for the Release of Confidential Information

I, _____
(Name of patient),
authorize _____
(Name or general designation of program making disclosure)
to disclose to
_____
(Name of person or organization to which disclosure is to be made)
the following information:

_____
___
(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to:

_____
___
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any

event this consent expires automatically as follows: (Specification of the date, event, or condition upon which this consent expires)	
(Date)	(Signature of defendant/patient)
	(Signature of parent, guardian, guardian, or authorized representative if required)